CHAPTER 149

MANDATORY HEALTH INSURANCE RISK−SHARING PLAN

149.10 Definitions. In this chapter:

(2) "Board" means the board of governors established under s. 149.15.

(2c) "Church plan" has the meaning given in section 3 (33) of the federal Employee Retirement Income Security Act of 1974.

(2f) "Commissioner" means the commissioner of insurance.

(2j) (a) Except as provided in par. (b), "creditable coverage" means coverage under any of the following:

1. A group health plan.

2. Health insurance.

3. Part A or part B of title XVIII of the federal Social Security Act.

4. Title XIX of the federal Social Security Act, except for coverage consisting solely of benefits under section 1928 of that act.

5. Chapter 55 of title 10 of the United States Code.

6. A medical care program of the federal Indian health service or of an American Indian tribal organization.

7. A state health benefits risk pool.

8. A health plan offered under chapter 89 of title 5 of the United States Code.

9. A public health plan.

10. A health coverage plan under section 5 (e) of the federal Peace Corps Act, 22 USC 2504 (e).

(b) "Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in section 2791 (c) of P.L. 104−191.

(2m) "Department" means the department of health and family services.

(2t) "Eligible individual" means an individual for whom all of the following apply:

(a) The aggregate of the individual's periods of creditable coverage is 18 months or more.

(b) The individual's most recent period of creditable coverage was under a group health plan, governmental plan, federal governmental plan or church plan, or under any health insurance offered in connection with any of those plans.

(c) The individual does not have creditable coverage and is not eligible for coverage under a group health plan, part A or part B of title XVIII of the federal Social Security Act or a state plan under title XIX of the federal Social Security Act or any successor program.

(d) The individual's most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or a failure to pay premiums.

(e) If the individual was offered the option of continuation coverage under a federal continuation provision or similar state program, the individual elected the continuation coverage.

(f) The individual has exhausted any continuation coverage under par. (e).

(3) "Eligible person" means a resident of this state who qualifies under s. 149.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

(3c) "Federal continuation provision" means any of the following:

(a) Section 4980B of the Internal Revenue Code of 1986, except for section 4980B (f) (1) of that code insofar as it relates to pediatric vaccines.

(b) Part 6 of subtitle B of title I of the federal Employee Retirement Income Security Act of 1974, except for section 609 of that act.

(c) Title XXII of P.L. 104−191.

(3d) "Federal governmental plan" means a benefit program established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government of the United States.

(3e) "Fund" means the health insurance risk−sharing plan fund.

(3g) "Governmental plan" has the meaning given under section 3 (32) of the federal Employee Retirement Income Security Act of 1974.

(3j) "Group health plan" means any of the following:

(a) An employee welfare plan, as defined in section 3 (1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the employee welfare plan provides medical care, including items and services paid for as medical care, to employees or to their dependents, as defined under the terms of the employee welfare plan, directly or through insurance, reimbursement, or otherwise.

(b) Any program that would not otherwise be an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the program provides medical care, including items and services paid for as medical care, to present or former partners of the partnership or to their dependents, as defined under the terms of the program, directly or through insurance, reimbursement or otherwise.

(3m) "Health care coverage revenue" means any of the following:

(a) Premiums received for health care coverage.

(b) Subscriber contract charges received for health care coverage.

(c) Health maintenance organization, limited service health organization or preferred provider plan charges received for health care coverage.

(d) The sum of benefits paid and administrative costs incurred for health care coverage under a medical reimbursement plan.

(4) "Health insurance" means surgical, medical, hospital, major medical and other health service coverage provided on an expense−incurred basis and fixed indemnity policies. "Health

insurance" does not include ancillary coverages such as income continuation, short−term, accident only, credit insurance, automobile medical payment coverage, coverage issued as a supplement to liability coverage, loss of time or accident benefits.

(4c) "Health maintenance organization" has the meaning given in s. 609.01 (2).

(4m) "HIV" means any strain of human immunodeficiency virus, which causes acquired immunodeficiency syndrome.

(4p) (a) "Insurance" includes any of the following:

1. Risk distributing arrangements providing for compensation of damages or loss through the provision of services or benefits in kind rather than indemnity in money.

2. Contracts of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction.

3. Plans established and operated under ss. 185.981 to 185.985.

(b) "Insurance" does not include a continuing care contract, as defined in s. 647.01 (2).

(5) "Insurer" means any person or association of persons, including a health maintenance organization, limited service health organization or preferred provider plan offering or insuring health services on a prepaid basis, including, but not limited to, policies of health insurance issued by a currently licensed insurer, as defined in s. 600.03 (27), 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 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 persons. "Insurer" does not include a plan under ch. 613 which offers only dental care.

(5m) "Limited service health organization" has the meaning given in s. 609.01 (3).

(6) "Medical assistance" means health care benefits provided under subch. IV of ch. 49.

(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 and administered under this chapter.

(8c) "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 issued by motor clubs.

(8j) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition of an individual that existed before the individual's date of enrollment for coverage, whether or not the individual received any medical advice or recommendation, diagnosis, care or treatment related to the condition before that date.

(8m) "Preferred provider plan" has the meaning given in s. 609.01 (4).

(8p) "Premium" means any consideration for an insurance policy, and includes assessments, membership fees or other required contributions or consideration, however designated.

(9) "Resident" means a person who has been legally domiciled in this state for a period of at least 30 days or, with respect to an eligible individual, an individual who resides in this state. For purposes of this chapter, 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.

(10) "Secretary" means the secretary of health and family services.

(11) "State" means the same as in s. 990.01 (40) except that it also includes the Panama Canal Zone.

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38; 2003 a. 33.

149.11 Operation of plan. The department shall promulgate rules for the operation of a plan of health insurance coverage for an eligible person which satisfies the requirements of this chapter.

History: 1979 c. 313; 1997 a. 27 s. 4825; Stats. 1997 s. 149.11.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

The federal Employee Retirement Income Security Act (ERISA) preempts any state law that relates to employee benefit plans. General Split Corp. v. Mitchell, 523 F. Supp. 427 (1981).

149.115 Rules relating to creditable coverage. The commissioner, in consultation with the department, shall promulgate rules that specify how creditable coverage is to be aggregated for purposes of s. 149.10 (2t) (a) and that determine the creditable coverage to which s. 149.10 (2t) (b) and (d) applies. The rules shall comply with section 2701 (c) of P.L. 104−191.

History: 1997 a. 27 s. 4825f; 1997 a. 237; 2001 a. 16.

149.12 Eligibility determination. (1) Except as provided in subs. (1m) and (2), the board or plan administrator shall certify as eligible a person who is covered by medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has tested positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, a person who is an eligible individual, and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

(a) A notice of rejection of coverage from one or more insurers.

(am) A notice of cancellation of coverage from one 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.

(1m) The board or plan administrator may not certify a person as eligible under circumstances requiring notice under sub. (1) (a) to (d) if the required notices were issued by an insurance intermediary who is not acting as an administrator, as defined in s. 633.01.

(2) (b) 1. Except as provided in subd. 2., no person who is covered under the plan and who 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.

2. Subdivision 1. does not apply to any person who is an eligible individual or to any person who terminates coverage under the plan because he or she is eligible to receive medical assistance benefits.

(c) No person on whose behalf the plan has paid out $1,000,000 or more is eligible for coverage under the plan.

(d) 1. Except as provided in subd. 2., no person who is 65 years of age or older is eligible for coverage under the plan.

2. Subdivision 1. does not apply to any of the following:

a. A person who is an eligible individual.

b. A person who has coverage under the plan on the date on which he or she attains the age of 65 years.

(e) No person who is eligible for creditable coverage, other than those benefits specified in s. 632.745 (11) (b) 1. to 12., that is provided by an employer on a self−insured basis or through health insurance is eligible for coverage under the plan.

(f) No person who is eligible for medical assistance is eligible for coverage under the plan.

(3) (a) Except as provided in pars. (b) to (c), no person is eligible for coverage under the plan for whom a premium, deductible or coinsurance amount is paid or reimbursed by a federal, state, county or municipal government or agency as of the first day of any term for which a premium amount is paid or reimbursed and as of the day after the last day of any term during which a deductible or coinsurance amount is paid or reimbursed.

(b) Persons for whom deductible or coinsurance amounts are paid or reimbursed under ch. 47 for vocational rehabilitation, under s. 49.68 for renal disease, under s. 49.685 (8) for hemophilia, under s. 49.683 for cystic fibrosis, under s. 253.05 for maternal and child health services or under s. 49.686 for the cost of drugs for the treatment of HIV infection or AIDS are not ineligible for coverage under the plan by reason of such payments or reimbursements.

(bm) Persons for whom premium costs for health insurance coverage are subsidized under s. 252.16 are not ineligible for coverage under the plan by reason of such payments.

(c) The department may promulgate rules specifying other deductible or coinsurance amounts that, if paid or reimbursed for persons, will not make the persons ineligible for coverage under the plan.

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12; 1999 a. 9.

Cross Reference: See also chs. HFS 119 and Ins 8.42, Wis. adm. code.

149.13 Participation of insurers. (1) Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under sub. (2) would be so minimal as to not exceed the estimated cost of levying the assessment. The commissioner shall advise the department of the insurers participating in the cost of administering the plan.

(2) Every participating insurer shall share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the insurer's total health care coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year, as determined by the commissioner.

(3) (a) Each insurer's proportion of participation under sub. (2) shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner. The commissioner shall assess an insurer for the insurer's proportion of participation based on the total assessments estimated by the department under s. 149.143 (2) (a) 3.

(b) If the department or the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 646 and 655 is not adequate to permit the department, the commissioner or the board to carry out the department's, commissioner's or board's responsibilities under this chapter, the commissioner shall promulgate rules requiring insurers to report the information necessary for the department, commissioner and board to make the determinations required under this chapter.

(4) Notwithstanding subs. (1) to (3), the department, with the agreement of the commissioner, may perform various administrative functions related to the assessment of insurers participating in the cost of administering the plan.

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269; 1997 a. 27 ss. 4834 to 4838; Stats. 1997 s. 149.13; 2001 a. 16.

149.14 Coverage. (1) COVERAGE OFFERED. (a) The plan shall offer in an annually renewable policy 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.

(b) If an individual terminates medical assistance coverage and applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 149.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of medical assistance 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 under this section shall pay an eligible person's covered expenses, subject to sub. (3) and deductible, copayment and coinsurance payments authorized under sub. (5), up to a lifetime limit of $1,000,000 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. Except as provided in sub. (4), except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the department under ss. 149.143 and 149.144, covered expenses for the coverage under this section shall be the payment rates established by the department under s. 149.142 for the services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as provided in sub. (4), except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the department under ss. 149.143 and 149.144, covered expenses for the coverage under this section shall also be the payment rates established by the department under s. 149.142 for the following services and articles if the service or article is prescribed by a physician who is licensed under ch. 448 or in another state and who is certified under s. 49.45 (2) (a) 11. and if the service or article is provided by a provider certified under s. 49.45 (2) (a) 11.:

(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, subject to the limitations in this subsection.

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

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

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

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

3. Subject to the limits under subd. 2. and to rules promulgated by the department, services for the chronically mentally ill in community support programs operated under s. 51.421.

(d) Drugs requiring a physician's prescription, subject to sub. (4c).

(e) Services of a licensed skilled nursing facility for eligible persons eligible for medicare, to the extent required by s. 632.895 (3) and for not more than an aggregate 120 days during a calendar year, if the services are of the type which would qualify as reimbursable services under medicare. Coverage under this paragraph which is not required by s. 632.895 (3) is subject to the deductible and coinsurance requirements under sub. (5).

(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 or disposable medical supplies, 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.

(nm) Hospice care provided by a hospice licensed under subch. IV of ch. 50.

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

(p) For persons not eligible for medicare, services of a licensed skilled nursing facility, only to the extent required by s. 632.895 (3).

(q) Any other health insurance coverage, only to the extent 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 for the coverage under this section 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. Breast reconstruction of the affected tissue incident to a mastectomy shall not be considered treatment for cosmetic purposes.

(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 that exceeds the payment rate established by the department under s. 149.142 and reduced under ss. 149.143 and 149.144 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. (3) (m) and (q).

(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 calendar year.

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

(m) Experimental treatment, as determined by the department.

(n) Services or drugs for the treatment of infertility, impotence or sterility.

(4c) COVERAGE OF PRESCRIPTION DRUGS. (a) The department may require a pharmacist or pharmacy that provides a prescription drug to an eligible person to submit a payment claim directly to the plan administrator.

(b) The department may limit coverage of prescription drugs under sub. (3) (d) to those prescription drugs for which payment claims are submitted by pharmacists or pharmacies directly to the plan administrator.

(4m) PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance or deductibles required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under ss. 149.142, 149.143 and 149.144 and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under s. 149.142, 149.143 or 149.144.

(5) DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND OUT−OF−POCKET LIMITS. (a) The plan shall offer a deductible in combination with appropriate premiums determined under this chapter 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. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. 149.165. For eligible persons under s. 149.165 (2) (a) 1., the deductible shall be $500. For eligible persons under s. 149.165 (2) (a) 2., the deductible shall be $600. For eligible persons under s. 149.165 (2) (a) 3., the deductible shall be $700. For eligible persons under s. 149.165 (2) (a) 4., the deductible shall be $800. For all other eligible persons who are not eligible for medicare, the deductible shall be $1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year.

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

(c) Except as provided in par. (e), if the aggregate of the covered costs not paid by the plan under par. (b) and the deductible exceeds $500 for an eligible person receiving medicare, $2,000 for any other eligible person during a calendar year or $4,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the calendar year after the payment ceilings under this paragraph are exceeded.

(d) Notwithstanding pars. (a) to (c), the department may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the department under s. 149.17 (4).

(e) Subject to sub. (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under sub. (3) (d) copayment amounts, coinsurance rates, and copayment and coinsurance out−of−pocket limits over which the plan will pay 100% of covered costs under sub. (3) (d). The department may provide subsidies for prescription drug copayment amounts paid by eligible persons under s. 149.165 (2) (a) 1. to 5. Any copayment amount, coinsurance rate, or out−of−pocket limit established under this paragraph is subject to the approval of the

board. Copayments and coinsurance paid by an eligible person under this paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

(5m) PREMIUM RATES. For the coverage required under this section, the premium rates charged to eligible persons with coverage under sub. (2) (b) shall be determined on the basis of the following factors:

(a) A comparison between the average per capita amount of covered expenses paid by the plan in the previous calendar year on behalf of eligible persons with coverage under sub. (2) (b) and the average per capita amount of covered expenses paid by the plan in the previous calendar year on behalf of eligible persons with coverage under sub. (2) (a).

(b) The enrollment levels of eligible persons with coverage under sub. (2) (b).

(c) Other economic factors that the department and the board consider relevant.

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

(b) An eligible individual who obtains coverage under the plan may not be subject to any preexisting condition exclusion under the plan.

(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, medical assistance or any other governmental program, except as otherwise provided by law.

(b) The department 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 department 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. Section 814.03 (3) applies to the department under this paragraph.

(8) APPLICABILITY OF MEDICAL ASSISTANCE PROVISIONS. (a) Except as provided in par. (b), the department may, by rule under s. 149.17 (4), apply to the plan the same utilization and cost control procedures that apply under rules promulgated by the department to medical assistance under subch. IV of ch. 49.

(b) The department may not apply to eligible persons for covered services or articles the same copayments that apply to recipients of medical assistance under subch. IV of ch. 49 for services or articles covered under that program.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33.

Cross Reference: See also s. HFS 119.12, Wis. adm. code.

149.142 Provider payment rates. (1) (a) Except as provided in par. (b), the department shall establish payment rates for covered expenses that consist of the allowable charges paid under s. 49.46 (2) for the services and articles provided plus an enhancement determined by the department. The rates shall be based on the allowable charges paid under s. 49.46 (2), projected plan costs and trend factors. Using the same methodology that applies to medical assistance under subch. IV of ch. 49, the department shall establish hospital outpatient per visit reimbursement rates and hospital inpatient reimbursement rates that are specific to diagnostically related groups of eligible persons.

(b) The payment rate for a prescription drug shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the department may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144.

(2) Except as provided in sub. (1) (b), the rates established under this section are subject to adjustment under ss. 149.143 and 149.144.

History: 1999 a. 9; 2001 a. 16.

149.143 Payment of plan costs. (1) The department shall pay or recover the operating costs of the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining premiums, insurer assessments and provider payment rate adjustments, the department shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

(am) A total of 60% from the following sources, calculated as follows:

1. First, from premiums from eligible persons with coverage under s. 149.14 (2) (a) set at a rate that is 140% to 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) set in accordance with s. 149.14 (5m), including amounts received for premium, deductible, and prescription drug copayment subsidies under s. 149.144, and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

2. Second, from moneys specified under sub. (2m), to the extent that the amounts under subd. 1. are insufficient to pay 60% of plan costs.

3. Third, by increasing premiums from eligible persons with coverage under s. 149.14 (2) (a) to more than the rate at which premiums were set under subd. 1. but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) by a comparable amount in accordance with s. 149.14 (5m), including amounts received for premium, deductible, and prescription drug copayment subsidies under s. 149.144, and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subds. 1. and 2. are insufficient to pay 60% of plan costs.

4. Fourth, notwithstanding par. (bm), by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subds. 1. to 3. are insufficient to pay 60% of plan costs.

(bm) A total of 40% as follows:

1. Fifty percent from insurer assessments, excluding assessments under s. 149.144.

2. Fifty percent from adjustments to provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144.

(2) (a) Prior to each plan year, the department shall estimate the operating and administrative costs of the plan and the costs of the premium reductions under s. 149.165, the deductible reductions under s. 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5) (e) for the new plan year and do all of the following:

1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set

at a level sufficient, when including amounts received for premium, deductible, and prescription drug copayment subsidies under s. 149.144 and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60% of the estimated plan costs for the new plan year.

b. Estimate the amount of enrollee premiums that will be received under sub. (1) (am) 1.

2. After making the determinations under subd. 1., by rule set premium rates for the new plan year, including the rates under s. 149.146 (2) (b), in the manner specified in sub. (1) (am) 1. and 3. and such that a rate for coverage under s. 149.14 (2) (a) is approved by the board and is not less than 140% nor more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

3. By rule set the total insurer assessments under s. 149.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) 1. and notify the commissioner of the amount.

4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year, subject to s. 149.142 (1) (b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) 2. and as provided in s. 149.145.

(b) In setting the premium rates under par. (a) 2., the insurer assessment amount under par. (a) 3. and the provider payment rate under par. (a) 4. for the new plan year, the department shall include any increase or decrease necessary to reflect the amount, if any, by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1) (am) and (bm) in the current plan year.

(2m) (a) The department shall keep a separate accounting of the difference between the following:

1. The amount of premiums received in a plan year from all eligible persons, including amounts received for premium, deductible, and prescription drug copayment subsidies.

2. The amount of premiums, including amounts received for premium, deductible, and prescription drug copayment subsidies, necessary to cover 60% of the plan costs for the plan year.

(b) Any amount by which the amount under par. (a) 1. exceeds the amount under par. (a) 2. may be used only as follows:

1. To reduce premiums in succeeding plan years as provided in sub. (1) (am) 2. For eligible persons with coverage under s. 149.14 (2) (a), premiums may not be reduced below 140% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

2. For other needs of eligible persons, with the approval of the board.

3. For distribution to eligible persons, notwithstanding any requirements in this chapter related to setting premium amounts. The department, with the approval of the board and the concurrence of the plan actuary, shall determine the policies, eligibility criteria, methodology, and other factors to be used in making any distribution under this subdivision.

(3) (a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (bm) 1., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. and s. 149.142 (1) (b).

(b) If the department increases premium rates and insurer assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (bm) but subject to s. 149.142 (1) (b).

(3m) Subject to s. 149.14 (4m), insurers and providers may recover in the normal course of their respective businesses without time limitation assessments or provider payment rate adjustments used to recoup any deficit incurred under the plan.

(4) Using the procedure under s. 227.24, the department may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the department is not required to make a finding of emergency.

(5) (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments, or provider payment rates, subject to s. 149.142 (1) (b), for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

(b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually, subject to s. 149.142 (1) (b). The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate, subject to s. 149.142 (1) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.
Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.144 Adjustments to insurer assessments and provider payment rates for premium, deductible, and prescription drug copayment reductions. The department shall, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ss. 149.142 (1) (b) and 149.143 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165, deductible reductions under s. 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5) (e). The department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

History: 1997 a. 27 ss. 4840c, 4845c; 1999 a. 9; 2001 a. 16; 2003 a. 33.
Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.145 Program budget. The department, in consultation with the board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in ss. 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143, 149.144, and 149.146 for determining premium rates, insurer assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject to s. 149.142 (1) (b), from the program budget the department shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The department may not implement a program budget established under this section unless it is approved by the board.

History: 1997 a. 27; 1999 a. 9; 2001 a. 16; 2003 a. 33.

149.146 Choice of coverage. (1) (a) Beginning on January 1, 1998, in addition to the coverage required under s. 149.14, the plan shall offer to all eligible persons who are not eligible for medicare a choice of coverage, as described in section 2744 (a) (1) (C), P.L. 104−191. Any such choice of coverage shall be major medical expense coverage.

(b) An eligible person under par. (a) may elect once each year, at the time and according to procedures established by the department, among the coverages offered under this section and s. 149.14. If an eligible person elects new coverage, any preexisting condition exclusion imposed under the new coverage is met to the extent that the eligible person has been previously and continuously covered under this chapter. No preexisting condition exclusion may be imposed on an eligible person who elects new coverage if the person was an eligible individual when first covered under this chapter and the person remained continuously covered under this chapter up to the time of electing the new coverage.

(2) (a) Except as specified by the department, the terms of coverage under s. 149.14, including deductible reductions under s. 149.14 (5) (a) and prescription drug copayment reductions under s. 149.14 (5) (e), do not apply to the coverage offered under this section. Premium reductions under s. 149.165 do not apply to the coverage offered under this section.

(am) 1. For all eligible persons with coverage under this section, the deductible shall be $2,500. Expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year.

2. Except as provided in subds. 3. and 5., if the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage in a calendar year, the plan shall pay at least 80% of any additional covered costs incurred by the person during the calendar year.

3. Except as provided in subd. 5., if the aggregate of the covered costs not paid by the plan under subd. 2. and the deductible exceeds $3,500 for any eligible person during a calendar year or $7,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the calendar year after the payment ceilings under this subdivision are exceeded.

4. Notwithstanding subds. 1. to 3., the department may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in subds. 1. to 3. in accordance with cost containment provisions established by the department under s. 149.17 (4).

5. Subject to s. 149.14 (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and copayment and coinsurance out−of−pocket limits over which the plan will pay 100% of covered costs for prescription drugs. Any copayment amount, coinsurance rate, or out−of−pocket limit established under this subdivision is subject to the approval of the board. Copayments and coinsurance paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

(b) The schedule of premiums for coverage under this section shall be promulgated by rule by the department, as provided in s. 149.143. The rates for coverage under this section shall be set such that they differ from the rates for coverage under s. 149.14 (2) (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).

2. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as the coverage offered under this section.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.15 Board of governors. (1) The plan shall have a board of governors consisting of representatives of 2 participating insurers that are nonprofit corporations, representatives of 2 other participating insurers, 3 health care provider representatives, including one representative of the State Medical Society of Wisconsin, one representative of the Wisconsin Health and Hospital Association and one representative of an integrated multidisciplinary health system, and 4 public members, including one representative of small businesses in the state, appointed by the secretary for staggered 3−year terms. In addition, the commissioner, or a designated representative from the office of the commissioner, and the secretary, or a designated representative from the department, shall be members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital, or an insurer. At least one of the public members shall be an individual who has coverage under the plan. The secretary or the secretary's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative and the secretary or the secretary'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 appropriate standing committees under s. 13.172 (3) and to the members of the plan 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.

(2m) Annually, beginning in 1999, the board shall submit a report on or before June 30 to the legislature under s. 13.172 (2) and to the governor on the operation of the plan, including any recommendations for changes to the plan.

(3) The board shall do all of the following:

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

(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 as provided under s. 149.143. 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.

(f) Advise the department on the choice of coverage under s. 149.146.

(g) Establish oversight committees to address various administrative issues, such as financial management of the plan and plan administrator performance standards. A representative of the department may not be the chairperson of any committee established under this paragraph.

(4) The board may do any of the following:

(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.

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

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

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

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

History: 1979 c. 313; 1981 c. 83; 1987 a. 186, 399; 1991 a. 269; 1997 a. 27 ss. 3027m, 3027r, 4861 to 4878; Stats. 1997 s. 149.15; 1999 a. 9; 2001 a. 16.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.16 Plan administrator. (1m) The plan administrator may be selected by the department in a competitive bidding process.

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

(b) The plan administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the department.

(c) The plan administrator 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 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised.

(e) The plan administrator, under the direction of the department, shall pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. If the plan administrator's payments for claims expenses exceed premium payments, the board shall forward to the department, and the department shall provide to the plan administrator, additional funds for payment of claims expenses.

(4) If the plan administrator is the fiscal agent under s. 49.45 (2) (b) 2., the plan administrator shall account for costs related to the plan separately from costs related to medical assistance.

(5) The department shall obtain the approval of the board before implementing any contract with the plan administrator.

History: 1997 a. 27 ss. 3030, 3031, 4882 to 4884c, 4886; 1999 a. 9; 2003 a. 33.

149.165 Reductions in premiums for low−income eligible persons. (1) Except as provided in s. 149.146 (2) (a), the department shall reduce the premiums established under s. 149.11 in conformity with ss. 149.14 (5m), 149.143 and 149.17 for the eligible persons and in the manner set forth in subs. (2) and (3).

(2) (a) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. 149.14 (2) (a) is equal to or greater than the first amount and less than the 2nd amount listed in any of the following, the department shall reduce the premium for the eligible person to the rate shown after the amounts:

1. If equal to or greater than $0 and less than $10,000, to 100% of 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).

2. If equal to or greater than $10,000 and less than $14,000, to 106.5% of 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).

3. If equal to or greater than $14,000 and less than $17,000, to 115.5% of 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).

4. If equal to or greater than $17,000 and less than $20,000, to 124.5% of 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).

5. If equal to or greater than $20,000 and less than $25,000, to 130% of 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).

(bc) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. 149.14 (2) (b) is equal to or greater than the first amount and less than the 2nd amount listed in par. (a) 1., 2., 3., 4. or 5., the department shall reduce the premium established for the eligible person by the same percentage as the department reduces, under par. (a), the premium established for an eligible person with coverage under s. 149.14 (2) (a) who has a household income specified in the same subdivision under par. (a) as the household income of the eligible person with coverage under s. 149.14 (2) (b).

(3) (a) Subject to par. (b), the department shall establish and implement the method for determining the household income of an eligible person under sub. (2).

(b) In determining household income under sub. (2), the department shall consider information submitted by an eligible person on a completed federal profit or loss from farming form, schedule F, if all of the following apply:

1. The person is a farmer, as defined in s. 102.04 (3).

2. The person was not eligible to claim the homestead credit under subch. VIII of ch. 71 in the preceding taxable year.

(3m) The board may approve adjustment of the household income dollar amounts listed in sub. (2) (a) 1. to 5., except for the first dollar amount listed in sub. (2) (a) 1., to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(4) The department shall reimburse the plan for premium reductions under sub. (2), deductible reductions under s. 149.14 (5) (a), and prescription drug copayment reductions under s. 149.14 (5) (e) from the appropriation under s. 20.435 (4) (v).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165; 2003 a. 33.

Cross Reference: See also s. HFS 119.12, Wis. adm. code.

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

(1) Subject to ss. 149.14 (5m), 149.143 and 149.146 (2) (b), a rating plan calculated in accordance with generally accepted actuarial principles.

(2) A schedule of premiums, deductibles, copayments and coinsurance payments that complies with all requirements of this chapter.

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

(4) Cost containment provisions established by the department by rule, including managed care requirements.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17; 1999 a. 9, 165.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.175 Waiver or exemption from provisions prohibited. Except as provided in s. 149.13 (1), the department may not waive, or authorize the board to waive, any of the requirements of this chapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this chapter.

History: 1991 a. 39; 1997 a. 27 s. 4901; Stats. 1997 s. 149.175.

149.18 Chapters 600 to 645 applicable. Except as otherwise provided in this chapter, the plan shall comply and be administered in compliance with chs. 600 to 645.

History: 1979 c. 313; 1981 c. 314; 1997 a. 27 s. 4902; Stats. 1997 s. 149.18.

149.20 Rule−making in consultation with board. In promulgating any rules under this chapter, the department shall consult with the board.

History: 1997 a. 27.

149.25 Case management pilot program. (1) DEFINITIONS. In this section:

(a) "Chronic disease" means any disease, illness, impairment, or other physical condition that requires health care and treatment over a prolonged period and, although amenable to treatment, is irreversible and frequently progresses to increasing disability or death.

(b) "Health professional shortage area" means an area that is designated by the federal department of health and human services under 42 CFR part 5, appendix A, as having a shortage of medical care professionals.

(2) PROGRAM AND ELIGIBILITY REQUIREMENTS. (a) The department shall conduct a 3−year pilot program, beginning on July 1, 2002, under which eligible persons who qualify under par. (b) are provided community−based case management services.

(b) To be eligible to participate in the pilot program, an eligible person must satisfy any of the following criteria:

1. Be diagnosed as having a chronic disease.

2. Be taking 2 or more prescribed medications on a regular basis.

3. Within 6 months of applying for the pilot program, have been treated 2 or more times at a hospital emergency room or have been admitted 2 or more times to a hospital as an inpatient.

(c) 1. Participation in the pilot program shall be voluntary and limited to no more than 300 eligible persons. The department shall ensure that all eligible persons are advised in a timely manner of the opportunity to participate in the pilot program and of how to apply for participation.

2. If more than 300 eligible persons apply to participate, the department shall select pilot program participants from among those who qualify under par. (b) according to standards determined by the department, except that the department shall give preference to eligible persons who reside in medically underserved areas or health professional shortage areas.

(3) PROVIDER ORGANIZATION AND SERVICES REQUIREMENTS. (a) The department shall select and contract with an organization to provide the community−based case management services under the pilot program. To be eligible to provide the services, an organization must satisfy all of the following criteria:

1. Be a private, nonprofit, integrated health care system that provides access to health care in a medically underserved area of the state or in a health professional shortage area.

2. Operate an existing community−based case management program with demonstrated successful client and program outcomes.

3. Demonstrate an ability to assemble and coordinate an interdisciplinary team of health care professionals, including physicians, nurses, and pharmacists, for assessment of a program participant's treatment plan.

(b) The community−based case management services under the pilot program shall be provided by a team, consisting of a nurse case manager, a pharmacist, and a social worker, working in collaboration with the eligible person's primary care physician or other provider. Services to be provided include all of the following:

1. An initial intake assessment.

2. Development of a treatment plan based on best practices.

3. Coordination of health care services.

4. Patient education.

5. Family support.

6. Monitoring and reporting of patient outcomes and costs.

(c) The department shall pay contract costs from the appropriation under s. 20.435 (4) (u).

(4) EVALUATION STUDY. The department shall conduct a study that evaluates the pilot program in terms of health care outcomes and cost avoidance. In the study, the department shall measure and compare, for pilot program participants and similarly situated eligible persons not participating in the pilot program, plan costs and utilization of services, including inpatient hospital days, rates of hospital readmission within 30 days for the same diagnosis, and prescription drug utilization. The department shall submit a report on the results of the study, including the department's conclusions and recommendations, to the legislature under s. 13.172 (2) and to the governor.

History: 2001 a. 16.