1997-98 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Joint Committee for Review of Administrative Rules

(JCR-AR)

Sample:

- Record of Comm. Proceedings
- 97hr_AC-EdR_RCP_pt01a
- 97hr_AC-EdR_RCP_pt01b
- 97hr_AC-EdR_RCP_pt02

- *Appointments ... Appt*
-
- *Clearinghouse Rules ... CRule*
-
- *Committee Hearings ... CH*
-
- *Committee Reports ... CR*
-
- *Executive Sessions ... ES*
-
- *Hearing Records ... HR*
-
- *Miscellaneous ... Misc*
- *97hr_JCR-AR_Misc_pt10*
- *Record of Comm. Proceedings ... RCP*
-

HFS 119 / INS 18 - HIRSP
HEALTH INS. RISK SHARING PROGRAM

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

OFFICE OF LEGAL COUNSEL

1 WEST WILSON STREET
P.O. BOX 7850
MADISON WI 53707-7850

TELEPHONE: (608) 266-8428

June 29, 1998

The Honorable Robert Welch, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 201, One East Main
Madison, Wisconsin

The Honorable Glenn Grothman, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 125 West, State Capitol
Madison, Wisconsin

Dear Senator Welch and Representative Grothman:

This is notification that the Department on Wednesday will publish an emergency rule order to repeal and recreate ch. HFS 119, rules for operation of the Health Insurance Risk-Sharing Plan (HIRSP). A copy of the emergency order is attached to this letter.

The current Budget Act, 1997 Wisconsin Act 27, transferred responsibility for administration of HIRSP from the Office of Commissioner of Insurance to the Department effective January 1, 1998. The Department then arranged for ch. Ins 18 to be renumbered ch. HFS 119 and for statutory references in the rules to be corrected since Act 27 had renumbered the program statute. The emergency rulemaking order to be published on July 1 will make changes in the rules that Act 27 made in the program statute or directed that the Department make by rule, and will update 4 sets of tables that show premiums for different types of policies or base rates for calculating premium reductions.

Section 9123 (4) of Act 27 permits the Department to promulgate any rules that it is authorized or required to promulgate under ch. 149, Stats., as affected by Act 27, by using emergency rulemaking procedures but without having to make a finding of emergency.

If you have any questions about these emergency rules, you may contact Kathy Rogers of the Department's Division of Health at 264-7733.

Sincerely,

Paul E. Menge

Paul E.Menge
Administrative Rules Manager

Attachments

6-23-98

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

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

Analysis Prepared by the Department of Health and Family Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORDER

Pursuant to authority vested in the Department of Health and Family Services by ss. 149.11, 149.12 (3) (c), 149.143 (2) (a) 2., 3. and 4., (3) (a) and (4), 149.144, 149.146 (2) (b) (intro.), 149.15 (5) and 149.17 (4), Stats., as affected by 1997 Wisconsin Act 27, and s. 9123 (4) of 1997 Wisconsin Act 27, the Department of Health and Family Services hereby repeals and recreates rules interpreting ch. 149, Stats., as affected by 1997 Wisconsin Act 27, as follows:

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

Chapter HFS 119

HEALTH INSURANCE RISK-SHARING PLAN

HFS 119.01 AUTHORITY AND PURPOSE. This chapter is promulgated under the authority of ss. 149.11, 149.12 (3) (c), 149.143 (2) (a) 2., 3. and 4., (3) (a) and (4), 149.144, 149.146 (2) (b) (intro.), 149.15 (5) and 149.17 (4), Stats., to establish requirements and procedures for the operation of a plan of health insurance coverage for persons who qualify under s. 149.12, Stats., for coverage because they cannot otherwise obtain it. Every insurer in the state offering health insurance is required by s. 149.13, Stats., to share in the operating, administrative and subsidy expenses of the plan.

HFS 119.02 APPLICABILITY. This chapter applies to the department, to the board of governors for the plan, to the plan administrator, to all insurers and to all eligible persons who receive health care coverage through the plan.

HFS 119.03 ESTABLISHMENT OF PLAN AND TITLE. In accordance with s. 149.11, Stats., a plan of health insurance coverage which meets the requirements of ch. 149, Stats., and s. 632.785, Stats., is established. The title of the plan shall be "Health Insurance Risk-Sharing Plan", and shall be referred to in this chapter as the plan.

HFS 119.04 DEFINITIONS. In this chapter:

(1) "Board" means the HIRSP board of governors established under s. 149.15, Stats.

(2) "Coinsurance" means the percentage of the allowed amount for which the HIRSP policyholder is responsible.

(3) " Commissioner" means the commissioner of insurance.

(4) "Creditable coverage" has the meaning specified in s. 149.10 (2j), Stats.

(5) "Deductible" means the amount, which HIRSP otherwise would pay, for which the HIRSP policyholder is responsible.

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

(7) "HIRSP" means the health insurance risk-sharing plan under this chapter

(8) "Insurer" has the meaning specified in s. 149.10 (5), Stats.

(9) "Managed care" means a program operated by an insurerto evaluate each patient's medical needs and to identify the appropriate treatments to meet those needs, with the primary goal of providing cost-effective health care without sacrificing quality of care or access.

(10) "Medicaid" means the medical assistance program operated by the department under ss 49.43 to 49.497, Stats., and chs. HFS 101 to 108.

(11) "Medically necessary" has the meaning specified in s. HFS 101.03 (96m).

(12) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 and 42 CFR subchapter B

(13) "Plan" means HIRSP.

(14) "Plan administrator" means the fiscal agent under s. 49.45 (2) (b) 2., Stats.

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

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

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

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

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

(19) "Resident" has the meaning specified in s. 149.10 (9), Stats.

(20) "Secretary" means the secretary of the department.

HFS 119.05 ELIGIBILITY. The plan administrator shall determine an applicant's eligibility for coverage under the plan in accordance with s. 149.12, Stats., and as follows:

(1) CRITERIA. The plan administrator shall certify as eligible any resident upon written receipt from the plan applicant of evidence that he or she meets any of the eligibility criteria set forth in s. 149.12 (1), Stats.

(2) NON-ELIGIBILITY. (a) Exclusions from eligibility for the plan shall be as set forth in s. 149.12 (2) and (3), Stats.

(b) For purposes of s. 149.12 (2) (b) 1., Stats., a person is considered to have voluntarily terminated coverage under the plan if the policy terminates because of failure to pay the premium unless the grievance committee of the board determines under s. HFS 119.14 (3) that the failure to pay was not intentional.

(3) SPECIAL ELIGIBILITY REQUIREMENTS. Section 149.12 (2) (e), Stats., does not preclude eligibility for coverage under the plan under any of the following conditions:

(a) When the health care benefits plan for which the person is eligible through his or her employer includes a rider excluding coverage for one or more of the person's conditions for more than 12 months or provides more limited coverage than the coverage available to others covered by the employer's plan.

(b) When the person has continued coverage under s. 632.897, Stats., or the federal consolidated omnibus budget reconciliation act of 1985, as amended.

(4) REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the plan administrator is entitled to a review under s. HFS 119.14. A request for review does not stay termination of coverage.

(5) DATE OF ELIGIBILITY. Coverage for a person certified as eligible for the plan begins on the date the plan receives the person's complete application or, at the request of the applicant, within 60 days following that date or, as provided in s. 149.14 (1) (b), Stats., on the date of termination of medical assistance coverage. Any individual anticipating termination under an individual plan or group health insurance policy or any other plan providing coverage similar to that under a health insurance policy, including medical assistance, may seek to establish eligibility for the plan prior to termination of existing coverage in order to maintain continuous coverage to the greatest extent possible.

(6) CREDITABLE COVERAGE. Pursuant to s. Ins 3.70, the method of aggregating creditable coverage for purposes of s. 149.10 (2t) (a), Stats., shall comply with 45 CFR 146.113 (a) (3).

HFS 119.06 PARTICIPATION OF INSURERS. (1) Every insurer shall share in the expenses of the plan as provided in s. 149.13 (2), Stats. In setting premiums under s. HFS 119.07 (6), the department shall not include any subsidies for the reduction of the cost of premiums or of deductibles in the calculation of operating and administrative costs of the plan. The commissioner may waive the assessment for an insurer or any class of insurers for any year when it is determined that the administrative costs of collecting the assessment would exceed the amount of the assessment.

(2) Every insurer shall file a copy of "Wisconsin health insurance risk-sharing plan assessment form," OCI 43-003, with its annual statement filed with the office of the commissioner of insurance.

Note: Copies of OCI 43-003 may be obtained from the Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701.

(3) An insurer who makes an error in the insurer's assessment form that results in an underpayment of assessments to the plan shall file a corrected assessment form with the office of the commissioner of insurance within 30 days after the error is discovered.

(4) An insurer that makes an error in an assessment form that results in an overpayment of assessments to the plan shall, at any time, file a corrected assessment form with the office of the commissioner of insurance. If the overpayment resulted from an assessment form filed in the previous calendar year, the plan shall credit the insurer's next annual assessment under s. 149.13, Stats., for the amount of the overpayment. If the insurer does not owe any amount for the next annual assessment, the plan shall refund the amount of

the overpayment. No credit or refund may be granted for an error in an assessment form filed in any year prior to the previous calendar year.

HFS 119.07 COVERAGE. (1) REQUIREMENTS. The plan shall offer coverage that complies with ss. 149.14 and 149.146, Stats., and this section.

(2) LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Pursuant to s. 149.14 (1), Stats., if an eligible person is also eligible for medicare coverage, the plan shall not pay or reimburse the person for expenses paid by medicare. As required by s.149.14 (2) (b), Stats., the plan offers under sub. (6) (b) and (c) an alternative for an individual eligible for medicare which reduces the benefits payable by the amounts paid under medicare.

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

(4) COVERED EXPENSES. Covered expenses shall be those services and articles enumerated in s. 149.14 (3), Stats., if the services are medically necessary, appropriate and cost effective, as determined by the plan administrator.

(5) EXCLUSIONS. Exclusions from coverage shall comply with s. 149.14 (4), Stats.

(6) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) Compliance with statutes. Premiums, deductibles and coinsurance shall be in compliance with ss. 149.14(5), 149.146, 149.165 and 149.17, Stats.

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

MAJOR MEDICAL PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,512	$1,368	$1,212
19-24	1,512	1,368	1,212
25-29	1,548	1,404	1,248
30-34	1,764	1,584	1,404
35-39	2,004	1,800	1,608
40-44	2,400	2,160	1,908
45-49	3,048	2,736	2,436
50-54	4,020	3,624	3,228
55-59	5,256	4,740	4,212
60+	6,468	5,820	5,172

MAJOR MEDICAL PLAN – Females

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

MEDICARE PLAN – Males

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

MEDICARE PLAN – Females

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

(c) Base rates for calculating premium reductions. 1. The annual base rates for calculating premium reductions under s. HFS 119.12 that are applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's major medical plan are as follows beginning July 1, 1998:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

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

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

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

2. The annual base rates for calculating premium reductions under s. HFS 119.12 that are applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's medicare plan are as follows beginning July 1, 1998:

MEDICARE PLAN – Males
(Base for Reduced Rates)

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

MEDICARE PLAN – Females
(Base for Reduced Rates)

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

(d) Annual premiums for major medical plan policies with $2500 deductible. In accordance with s. 149.146, Stats., an alternative plan of health insurance involving major medical expense coverage is established with a $2,500 deductible. The schedule of annual premiums for coverage under the alternative plan with a $2,500 deductible is as follows beginning July 1, 1998:

ALTERNATIVE MAJOR MEDICAL PLAN –
Males

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

ALTERNATIVE MAJOR MEDICAL PLAN – Females

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

(e) Zones. For the purposes of pars. (b), (c) and (d), Zone 1 shall contain all of the Wisconsin zip code areas in which the first 3 digits are 532. Zone 2 shall contain postal zip code areas in which the first 3 digits are 530, 531, 534 and 537. Zone 3 shall contain postal zip code areas not contained in Zones 1 and 2.

(f) Detailed description of how premium rates are set. 1. The department shall have on file an actuarial report detailing the process by which rates were determined.

2. The annual report of the board to the chief clerk of each house of the legislature required by s. 149.15(2), Stats., and s. HFS 119.08 (2) shall include a section describing premium rate-setting in detail. In order to fulfill this requirement, the board may appoint an actuarial committee under the powers granted to the board in s. 149.15 (5), Stats., and s. HFS 119.08 (3) (d).

(7) PREEXISTING CONDITIONS. Preexisting conditions limitations shall conform with s. 149.14 (6), Stats. Determinations of what constitutes a preexisting condition shall be made by the plan administrator.

(8) COORDINATION OF BENEFITS. Benefits shall be coordinated as provided in s. 149.14 (7), Stats.

(9) RIGHT TO REVIEW. Any person whose claim is denied or reduced by the plan administrator is entitled to a review under s. HFS 119.14.

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

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

(3) BOARD FUNCTIONS. (a) The board shall carry out the functions specified in s. 149.15 (3), Stats., and any other function specified for the board in this chapter.

(b) The board may carry out the functions authorized in s. 149.15 (4), Stats.

(c) The board may provide for agent commissions and require agents and companies to provide assistance in filing applications.

(d) The board may establish subcommittees and appoint members who do not serve on the board to the subcommittees.

HFS 119.09 PLAN ADMINISTRATOR. The plan administrator shall carry out the functions under s. 149.16 (3), Stats., and any other function of the plan administrator specified in this chapter.

HFS 119.10 NOTIFICATION BY INSURERS OF AVAILABILITY OF HIRSP. (1) WHEN NOTICE REQUIRED. If an insurer takes one or more of the actions enumerated in s. 632.785 (1), Stats., the insurer shall notify all persons covered or to be covered by the policy, including parents and guardians in cases involving minor children and individuals adjudged incompetent under ch. 880, Stats., of the existence of HIRSP, as well as the eligibility requirements and how to apply for coverage under the plan, as required by s. 632.785 (1), Stats.

(2) FORM OF NOTICE. An insurer who takes one or more of the actions under s. 632.785 (1), Stats., shall satisfy the notice requirement under sub. (1) by providing each person covered or to be covered by the policy with a copy of "Wisconsin Health Insurance Risk-Sharing Plan (HIRSP)," an informational pamphlet prepared by the department.

Note: Copies of the informational pamphlet may be obtained from EDS, Health Insurance Risk-Sharing Plan (HIRSP), Suite #18, 6406 Bridge Road, Madison, Wisconsin 53784-0018 (phone 608-221-4551 or 1-800-828-4777).

(3) STATEMENT OF REASONS FOR REJECTING, TERMINATING OR CANCELING COVERAGE OR IMPOSING UNDERWRITING RESTRICTIONS. If an insurer rejects, terminates or cancels coverage or imposes underwriting restrictions under 632.785 (1), Stats., the insurer is obligated under s. 632.785 (2), Stats., to include in the notice required under sub. (1) a statement giving the specific medical reasons for the insurer's action.

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

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

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

HFS 119.12 PREMIUM AND DEDUCTIBLE REDUCTIONS FOR LOW-INCOME POLICYHOLDERS. (1) PURPOSE. The purpose of this section is to interpret and implement ss. 149.14 (5) and 149.165, Stats.

(2) ELIGIBILITY. Applicants for coverage under the plan may apply for the reductions under this section. Persons covered under the plan shall reapply annually.

(3) CALCULATION OF PREMIUM AND DEDUCTIBLE REDUCTIONS. (a) The base rates for calculating premium reductions under s. 149.165 (1) and (2), Stats., are set forth in s. HFS 119.07 (6) (c).

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

(c) The plan administrator may reassess the household income of an eligible person at any time during the term of the person's policy. If an eligible person's household income changes during a policy term, the plan administrator may, if appropriate under s. 149.165 (2), Stats., revise the premium for the person in conformity with s. 149.165 (2), Stats., and the deductible for the person under s. 149.14(5) (a), Stats., for the remainder of the policy term. The revised premium and deductible shall take effect the first month beginning after the plan administrator's decision.

(d) The availability of premium and deductible reductions is based on the availability of funds appropriated under s. 20.435 (5) (ah), Stats., including the provisions of s. 149.144, Stats.

(4) APPLICATION FOR PREMIUM AND DEDUCTIBLE REDUCTIONS. An application for premium and deductible reductions is not complete until a Supplemental Application for Premium and Deductible Reduction form or a completed Wisconsin Homestead Credit Schedule H is submitted to the plan administrator. A complete application for premium and deductible reduction may also need to include a completed federal profit or loss from farming form, schedule F. An application for the premium and deductible reduction shall be accompanied by or preceded by an application to the plan.

Note: A person may obtain the supplemental application for premium and deductible reductions at no charge from EDS, Health Insurance Risk-Sharing Plan (HIRSP), 6406 Bridge Road, Suite #18, Madison, Wisconsin 53784-0018 (phone 608-221-4551 or 1-800-828-4777.)

(5) APPLICATION DEADLINES, EFFECTIVE DATES OF REDUCTIONS AND REESTABLISHMENT OF ELIGIBILITY. (a) New plan applicants and new policyholders. New plan applicants may request eligibility for the reductions at any of the following times:

1. At the time of plan application. In this case, for purposes of the premium reduction, the plan administrator shall make the appropriate adjustments regarding the applicant's initial premium payment submitted with the application. Deductible reductions take effect upon issuance of the policy.

2. After eligibility for the plan is established. a. If eligibility for the premium reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of the reduced portion of the premium retroactive to the effective date of the policy. If eligibility for the reduced premium is not established within 31 days after the effective date of the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the renewal date on which it is to take effect, and the plan administrator shall bill the policyholder for the reduced premium beginning on the renewal date.

b. If eligibility for the deductible reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of a portion of the deductible paid by the policyholder prior to establishing eligibility. The amount of the refund shall be the difference between the deductible paid by the policyholder and the deductible as reduced by any reduction to which the policyholder is entitled. If eligibility is not established within 31 days after the effective date of the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the policy's renewal date, and the deductible reduction shall take effect on January 1 of the year commencing after the policy's renewal date.

(b) 1. Existing policy holders. Persons who are existing policyholders as of March 31 shall apply annually by May 1 in order to be eligible for the reductions for the year beginning on July 1.

2. For premium reductions, if the application is not postmarked by May 1, then the application shall be postmarked at least 60 days prior to the policyholder's next policy renewal date in order for the corresponding premium notice to reflect the reduced premium. An existing policyholder who is first determined to be eligible for a premium reduction shall receive a refund on a pro rata basis for the time period between July 1 of each calendar year and the next renewal date.

3. Deductible reductions under this paragraph take place on January 1 of the year following establishment of eligibility.

(c) Under this subsection, the plan administrator shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(d) Eligibility for the premium and deductible reductions shall be reestablished at least annually.

(6) RIGHT TO REVIEW. An applicant who is denied a premium or deductible reduction is entitled to a review under s. HFS 119.14.

HFS 119.13 COST CONTAINMENT PROVISIONS. HIRSP may use common, current methods employed by managed care programs and the medicaid program to contain costs, including prior authorization and other limitations regarding healthcare utilization and reimbursement. When a new policy is issued, the plan administrator shall send the new policyholder a written description of the plan's cost containment provisions and the procedures that the policyholder shall follow in order to comply with these cost containment provisions. The plan administrator shall send existing policyholders a written description of any change to the plan's cost containment provisions or the procedures that policyholders shall follow in order to comply with these cost containment provisions. The existing policyholders shall receive this written description at least 60 days before the change takes effect.

HFS 119.14 GRIEVANCE PROCEDURE. (1) PURPOSE. This section implements s. 149.17 (3), Stats.

(2) REVIEW BY PLAN ADMINISTRATOR. A person entitled under this chapter to a review of a determination by the plan administrator shall, within 60 days of the date of the letter of determination, submit a written request to the plan administrator that the determination be reviewed. Upon receipt of a request, the plan administrator shall review the original determination, either affirm, modify or rescind it and provide the requester with a written response which includes the plan administrator's final decision and the reason for it. The plan administrator shall have 10 days from receipt of a request for review to issue a letter of decision or a letter to the requester asking for additional information.

Note: To request a review by the plan administrator, write: EDS-HIRSP, 6406 Bridge Road, Suite #18, Madison, WI 53784-0018.

(3) REVIEW BY GRIEVANCE COMMITTEE OF THE BOARD. (a) If a decision under sub. (2) is adverse to an applicant or policyholder, the applicant or policyholder may request a review of the decision by the grievance committee of the board. A request for review under this subsection shall be made in writing to the board within 30 days of the date of the letter of decision under sub. (2) and shall clearly describe the reason the requester believes the plan administrator's decision is erroneous under ch. 149, Stats., this chapter or the terms of the plan policy.

Note: To request a review by the grievance committee of the board, write: HIRSP Board Grievance Committee, P.O. Box 309, Madison, WI 53701-0309.

(b) The board shall appoint a grievance committee of at least 5 persons, a majority of whom are not members of the board, to review decisions of the plan administrator that

adversely affect applicants and policyholders entitled to review under this chapter. Upon the written request of an applicant for HIRSP or a policyholder, the grievance committee shall conduct a review based on written submissions by the plan administrator and the applicant or policyholder. No discovery is permitted. The grievance committee may invite or permit representatives of the plan administrator and the applicant or policyholder to appear and make oral statements during the review. The grievance committee shall, within 45 days from the receipt of the applicant's or policyholder's request for review, issue a written decision affirming, modifying or rescinding the decision of the plan administrator and stating the reason for its decision. The committee's decision shall be final, unless the secretary of the department deems a different decision is in the best interests of the state of Wisconsin.

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

(4) RESPONSIBILITY OF PLAN ADMINISTRATOR. The plan administrator shall comply with the final decision of the board's grievance committee or the secretary.

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

(2) INSURER ASSESSMENTS. The insurer assessments for the time period July 1, 1998 through December 31, 1998 total $ 4,266,874.

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

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

Wisconsin Department of Health and Family Services

Dated: 6-25-98

By: _____
Joseph Leean
Secretary

SEAL:

APR 20 1998

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

Les.
DHFS sent this to us by mistake.
Also, enjoy the inmate mail
John

April 20, 1998

The Honorable Richard Grobschmidt , Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 404, 100 N. Hamilton
Madison, Wisconsin

Dear Senator Grobschmidt:

The Office of Commissioner of Insurance (OCI) published two emergency rulemaking orders in late 1997 to take effect on January 1, 1998, that amended ch. Ins 18, rules for operation of the Health Insurance Risk-Sharing Plan (HIRSP), formerly under subch. II of ch. 619, Stats., and now under ch. 149, Stats. That program was transferred, effective January 1, 1998, from OCI to the Department of Health and Family Services by ss. 9127 (2) and 9427 (1m) of 1997 Wisconsin Act 27 together with all rules for HIRSP promulgated by OCI that were in effect on that date. The first set of emergency rules related to a $2500 deductible alternative to the health insurance risk-sharing plan and the second set to a decrease in premium rates for nonsubsidized policyholders only. Both emergency rulemaking orders will expire on May 31, 1998, before the emergency rules are replaced by permanent rules unless the effective period of the emergency orders is extended. Pursuant to s. 227.24(2), Stats., I ask the Joint Committee to extend the effective period of both emergency orders by 31 days, through June 30, 1998.

The first emergency order, which amends s. Ins 18.07 (intro.) and (5) (a) and (br) and creates s. Ins 18.07 (5) (bm), implements the requirement contained in s. 149.146, Stats. (formerly, s. 619.146, Stats.) to offer, beginning January 1, 1998, a major medical expense coverage plan with a $2500 deductible as an alternative to the standard HIRSP plan.

The second emergency order, which repeals and recreates s. Ins 18.07 (5) (b) and was amended after publication but before the effective date to correct four numbers in the tables, implements the requirement in ss. 149.11 and 149.14 (5) (a), Stats. (formerly, ss. 619.11 and 619.14 (5) (a), Stats.) that the schedule of premiums be promulgated by rule. In this instance, amended tables were published based on recommendations of the HIRSP Board of Governors that reduced premiums for nonsubsidized policyholders. This reduction of rates was mandated by plan financing changes included in 1997 Wisconsin

Act 27. Section 149.14 (5) (e), Stats. (formerly, s. 619.14 (5) (e), Stats.) authorizes the promulgation of a revised schedule of premiums by use of emergency rulemaking procedures.

Copies of the emergency rulemaking orders are attached to this letter. If you have any questions about the rules, you may contact Kathy Rogers of the Department's Division of Health at 264-7733.

Sincerely,

Joe Leean
Secretary

Attachments

cc Representative Grothman
Acting Commissioner Randy Blumer, OCI

#1

EMERGENCY ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AMENDING and CREATING a RULE

To amend Ins 18.07 (intro), (5)(a) and (5)(br) and to create Ins. 18.07 (5) (bm) relating to the creation of a $2500 deductible alternative to the health insurance risk-sharing plan effective January 1, 1998.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 227.24, 601.41 (3), 619.11, 619.14 (5) (a) and (e), 619.17 (2) and 619.146, Stats.

Statutes Interpreted: s. 619.146 Stats.

January 1, 1998 health insurance risk sharing plan with $2500 deductible.

This change is mandated by 1997 Wisconsin Act 27 which created s. 619.146 Stats. This section requires that an alternative major medical expense coverage plan be offered with a $2500 deductible as described in section 2744 (a) (1) (C) of P.L. 104-191. Under s. 619.146 (2) (a) premium reductions do not apply to this alternative plan. Section 619.146 (2) (b) prescribes how the rates for the alternative plan are to be determined. Since the alternative plan is required by law to be offered by January 1, 1998 this emergency rule sets out the rates for that plan.

Exemption From Finding of Emergency

Pursuant to s. 619.14 (5) (e) Stats. the commissioner is not required to make a finding of an emergency to promulgate this emergency rule.

SECTION 1. Section Ins 18.07 (intro) is amended to read:

Ins 18.07 Coverage. Coverage shall conform with s. 619.14 and 619.146 Stats.

SECTION 2. Section Ins 18.07 (5) (a) is amended to read:

Ins 18.07 (5) PREMIUMS DEDUCTIBLES AND COINSURANCE. (a) Premiums, deductibles and coinsurance shall conform with ss. 619.14 (5), 619.146, 619.165 and 619.17, Stats.

SECTION 3. Section 18.07 (bm) is created to read:

Ins 18.07 (bm) The annual premiums for coverage under the alternative plan with a $2500 deductible are as follows:

ALTERNATIVE MAJOR MEDICAL PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1020	$924	$816
19-24	1020	924	816
25-29	1044	936	840
30-34	1176	1056	936
35-39	1320	1188	1056
40-44	1608	1452	1284
45-49	1980	1788	1584
50-54	2568	2316	2052
55-59	3360	3024	2688
60-64	4104	3696	3288

ALTERNATIVE MAJOR MEDICAL PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	1020	924	816
19-24	1428	1284	1140
25-29	1488	1344	1188
30-34	1644	1476	1320
35-39	1776	1596	1416
40-44	1944	1752	1560
45-49	2244	2016	1800
50-54	2556	2304	2040
55-59	2904	2616	2328
60-64	3432	3084	2748

SECTION 3. Section Ins 18.07 (5) (br) is amended to read:

Ins 18.07 (5) (br) for the purposes of pars. (b), (bg) and (bm), 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.

SECTION 4. EFFECTIVE DATE. This rule will take effect on January 1, 1998, pursuant to s. 227.24 (1) (c), Stats.

Dated at Madison, Wisconsin, this 23rd day of December 1997.

Randy Blumer

RANDY BLUMER
Deputy Commissioner of Insurance

#2.a.

EMERGENCY ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

REPEALING AND RECREATING A RULE

To repeal and recreate Ins 18.07 (5)(b) relating to an decrease in premium rates for the health insurance risk-sharing plan effective January 1, 1998.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 227.24, 601.41 (3), 619.11, 619.14 (5) (a) and (e) and 619.15 (5), Stats.

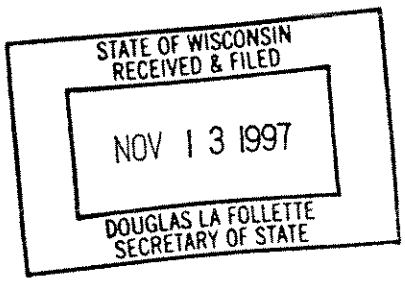
Statutes Interpreted: ss. 619.14 (5) (a), 619.165 (1) and 619.17 (1) and (2), Stats.

January 1, 1998 Premium Adjustments

The Commissioner of Insurance, based on the recommendation of the Health Insurance Risk-Sharing Plan ("HIRSP") board, is required to set the annual premiums by rule. The rates must be calculated in accordance with generally accepted actuarial principles. This rule adjusts the non-subsidized premium rates effective January 1, 1998. This change in rates will result in a reduction of approximately 14.5% and is mandated by plan financing changes in 1997 Wisconsin Act 27.

Exemption From Finding of Emergency

Pursuant to s. 619.14 (5) (e) Stats. the commissioner is not required to make a finding of an emergency to promulgate this emergency rule.



1807e97.doc
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SECTION 1. Section Ins 18.07 (5) (b) is repealed and recreated to read:

Ins 18.07 (5) (b) 1. The schedule of annual premiums for non-subsidized policyholders is as follows.

MAJOR MEDICAL PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	1428	1284	1140
19-24	1428	1284	1140
25-29	1464	1320	1176
30-34	1644	1476	1320
35-39	1836	1656	1464
40-44	2232	2004	1788
45-49	2760	2484	2208
50-54	3564	3204	2856
55-59	4663	4200	3732
60-64	5772	5136	4572

MAJOR MEDICAL PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	1428	1284	1140
19-24	1980	1788	1584
25-29	2070	1872	1656
30-34	2292	2064	1836
35-39	2472	2220	1980
40-44	2700	2436	2160
45-49	3120	2808	2496
50-54	3552	3192	2844
55-59	4032	3624	3228
60-64	4776	4296	3816

MEDICARE PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	720	648	576
19-24	720	648	576
25-29	720	648	576
30-34	828	747	660
35-39	924	828	744
40-44	1116	1008	888
45-49	1392	1248	1116
50-54	1788	1608	1428
55-59	2340	2112	1872
60-64	2868	2580	2292

MEDICARE PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	720	648	576
19-24	996	900	792
25-29	1044	936	840
30-34	1140	1032	912
35-39	1224	1104	984
40-44	1356	1224	1080
45-49	1572	1416	1260
50-54	1764	1584	1416
55-59	2016	1812	1608
60-64	2376	2136	1896

SECTION 2. EFFECTIVE DATE. This rule will take effect on January 1, 1998, pursuant to s. 227.24 (1) (c), Stats.

Dated at Madison, Wisconsin, this 11 day of November 1997

Josephine W. Musser
Commissioner of Insurance

#2.b.

EMERGENCY ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AMENDING AN EMERGENCY RULE

To amend an emergency rule promulgated to be effective January 1, 1998 relating to a decrease in premium rates for the health insurance risk-sharing plan under Ins. 18.07 (5) (b) to correct errors in the published rate table.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 227.24, 601.41 (3), 619.11, 619.14 (5) (a) and (e) and 619.15 (5), Stats.

Statutes Interpreted: ss. 619.14 (5) (a), 619.165 (1) and 619.17 (1) and (2), Stats.

January 1, 1998 Premium Adjustment Correction

The Commissioner of Insurance, based on the recommendation of the Health Insurance Risk-Sharing Plan (''HIRSP'') board, is required to set the annual premiums by rule. The rates must be calculated in accordance with generally accepted actuarial principles. An emergency rule, already promulgated and published, adjusts the non-subsidized premium rates effective January 1, 1998. This emergency amendment corrects 4 errors in the published rate table.

Exemption From Finding of Emergency

Pursuant to s. 619.14 (5) (e) Stats. the commissioner is not required to make a finding of an emergency to promulgate this emergency amendment to an emergency rule.

SECTION 1. Section Ins 18.07 (5) (b) is amended to read:

Ins 18.07 (5) (b) 1. The schedule of annual premiums for non-subsidized policyholders is as follows.

MAJOR MEDICAL PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	1428	1284	1140
19-24	1428	1284	1140
25-29	1464	1320	1176

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SECRETARY OF STATE

30-34	1644	1476	1320
35-39	1836	1656	1464
40-44	2232	2004	1788
45-49	2760	2484	2208
50-54	3564	3204	2856
55-59	~~4662~~ 4668	4200	3732
60-64	~~5772~~ 5712	5136	4572

MAJOR MEDICAL PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	1428	1284	1140
19-24	1980	1788	1584
25-29	~~2070~~ 2076	1872	1656
30-34	2292	2064	1836
35-39	2472	2220	1980
40-44	2700	2436	2160
45-49	3120	2808	2496
50-54	3552	3192	2844
55-59	4032	3624	3228
60-64	4776	4296	3816

MEDICARE PLAN - Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	720	648	576
19-24	720	648	576
25-29	720	648	576
30-34	828	~~747~~ 744	660
35-39	924	828	744
40-44	1116	1008	888
45-49	1392	1248	1116
50-54	1788	1608	1428
55-59	2340	2112	1872

60-64	2868	2580	2292

MEDICARE PLAN - Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	720	648	576
19-24	996	900	792
25-29	1044	936	840
30-34	1140	1032	912
35-39	1224	1104	984
40-44	1356	1224	1080
45-49	1572	1416	1260
50-54	1764	1584	1416
55-59	2016	1812	1608
60-64	2376	2136	1896

SECTION 2. EFFECTIVE DATE. This amended rule will take effect on January 1, 1998, pursuant to s. 227.24 (1) (c), Stats.

Dated at Madison, Wisconsin, this 1st day of December 1997.

Randy Blumer

Deputy Commissioner of Insurance

APR 20 1998

April 19, 1998

Joint Committee for Review of Administrative Rules
Senator Grobschmidt
P.O. Box 7882
Madison, WI. 53707-7882

MAY 06 1998

File

Dear Senator Grobschmidt,

I am planning a civil lawsuit against Gary McCaughtry, Warden of the Waupun Correctional Institution. I have exhausted all available administrative remedies and timely and properly filed a notice of claim against him.

I recently learned that in addition to having the summons and complaint served on McCaughtry, I must also serve one to the State Attorney General and to your committee.

Since your committee apparently reviews administrative rules, perhaps you can take action to make my civil suit unnecessary.

In March of 1997 while incarcerated at the Green Bay Correctional Institution I was found guilty of a drug related offense by the disciplinary committee. I was sentenced to 8 days adjustment segregation and 360 days program segregation. In July of 1997, I was transferred to WCI where I was released from segregation and placed in general population on September 1, 1997.

On or about September 7, 1997 I applied for work as a steamfitter with the maintenance Dept., at WCI at which time I learned that the Sergeant at Maintenance wanted to hire me but that because of the Warden's policy on drug related offenses I would not be alloed to work at any job for a period of at least 1 year following my release from segregation.

The policy in question and the main subject of my lawsuit is WCI policy and procedure #708.14(D)(3)(b) which states: "Inmates found guilty of assaultive, weapons, escape, or drug-related offenses will be eligible for a work assignment no sooner than twelve (12) months from their release from segregation." The effective date for this policy is 11/10/97. (See enclosed photocopy)

It is my belief that this policy exceeds the Wardens authority to promulgate and implement policy for the following reasons:

1. Wis. Admin. Code DOC 303.84 sets the maximum penalty for any given offense. Policy #708.14(D)(3)(b) is purely punative in nature and exceeds the intent and purpose of DOC 303.84 by imposing an additional year (at minimum) of punishment.

2. Wis. Admin. Code DOC 303.08(2) provides that "...Each inmate in a maximum security institution shall be given a copy of all bulletins which are applicable to him or her." At no time was I given a copy of Policy #708.14.

3. Wis. Admin. Code 302.15(1) provides "...every resident is eligible for every job..."

4. Wis. Admin. Code 302.15(2) states "Each resident shall be offered a program assignment, consistent with available resources and security needs." I believe the wording in this section creates an entitlement to work if work is available. Work is/was available for me but was denied me pursuant to this policy 708.14(D)(3)(b), (see enclosed form DOC 1408.)

5. Keeping in mind that it is well established in Wisconsin that a properly promulgated Administrative code has the force and effect of law, sec. 227.10(2), Stats., states "No agency may promulgate a rule which conflicts with state law." See also Plumbers Local No. 75 v. Coughlin, 481 N.W.2d 297 at 302, Zimmerman v. DHSS, 485 N.W.2d 290, where regulation, manual handbook is inconsistant to a statute, statute is applied., and Lisney v. L.I.R.C., 493 N.W.2d 14, 16 ("[a] court does not... give deference to an agency's interpretation which... is clearly contrary to legislative intent..." Policy #708.14(D)(3)(b) is clearly contrary to DOC 303.84 which does not allow for "sentence enhancers" which is clearly the purpose of the Wardens policy. The Wardens policy also flies in the face of DOC 302 (1) and (2).

6. My rule violation took place in a different institution, I was sentenced to a specific punishment at that institution, said sentencing taking place well before Policy #708 became effective. I do not believe a policy may be imposed retroactively if it affects a liberty interest.

7. Prison officials must submit evidence that interests that they cite are the actual reasons for the policy. Swift v. Lewis 901 F.2d 730. I do not believe the Warden can show, especially in my case, that his policy is anything but punative, willful, and malicious.

Please contact me with your thoughts on this matter and any action you may or may not take. I will wait a reasonable amount of time to hear from you before taking any further action.

Sincerely,

Michael Boshcka #81483-A
Waupun Corr. Inst.
P.O. Box-351
Waupun, WI. 53963-0351

cc: file

6. All completed PRC Work/Program Assignment (DOC-1408) forms (see attached) must be signed by the supervisor requesting to hire the inmate. The signature should be placed at the bottom of the "comment" section.

WCI LIBRARY

C. SCHOOL REFERRAL PROCESS

1. The Education Department will complete a PRC Work/Program Assignment (DOC-1408) form to add or drop an inmate from a school program.

2. With prior approval of the Education Director/ School Counselor, inmates leaving a school program can be considered for another assignment.

D. WORK ASSIGNMENT PROCESS

1. Work supervisors will provide written notification on a PRC Work/Program Assignment form (DOC-1408) to the Work/Program Assignment Committee indicating an interest in hiring a specific inmate. Vacant position numbers must be included in this request for hire.

2. If special skills or requirements exist for a work assignment, the work supervisor shall submit a PRC Work/Program Assignment form (DOC-1408) requesting a specific inmate be assigned to that position. Included in this request will be the position number and summary of the inmate's special skills for that position. This form will be submitted to the committee for approval and processing.

3. In regard to specific disciplinary violations, the following work assignment guidelines will apply:

   a. Inmates found guilty of offenses for which a major sanction is imposed, other than adjustment segregation, will be eligible for a work assignment no sooner than six (6) months from their release from segregation, except for those listed in "b" below.

b. Inmates found guilty of assaultive, weapons, escape, or drug-related offenses will be eligible for a work assignment no sooner than twelve (12) months from their release from segregation.

E. ROUTING PROCEDURES

1. The Work/Program Assignment Committee will review submitted PRC Work/Program Assignment (DOC-1408) forms and approve or disapprove the request. If the assignment request is disapproved, the DOC-1408 forms will then be removed from the file and the permanent work/program assignments will be denoted in the Social Worker's summary comment section.

F. VOLUNTARY TERMINATION

1. Inmates who voluntarily terminate their work/program assignment will do so utilizing a Voluntary Termination form (see attached).

2. Inmates choosing to voluntarily terminate their work/program assignment will be placed in Voluntary Unassigned status. Placement in Voluntary Unassigned status after termination will be for a minimum of one hundred twenty (120) days.

WCI LIBRARY

11/97:kle

DEPARTMENT OF CORRECTIONS
Office of Offender Classification
DOC-1408 (Rev. 11/93)

WISCONSIN
Administrative Code
Chapter DOC 302

PRC WORK/PROGRAM ASSIGNMENTS

INMATE NAME	INMATE NUMBER	INSTITUTION
BOSHCKA, MICHAEL F.	81483	WCI

ACTION TYPE	FROM	TO	EFFECTIVE DATE
☒ Assigned ☐ Removed ☐ Transferred	IN	EMC/YARD	3-16-98

COMMENTS

Please assign Inmate Boshcka to job #247 STEAMFITTER.

on hire list

Sgt. D. Krause, EMC/YARD SGT., 3-12-1998

PRC PROGRAM ASSISTANT SIGNATURE: Sherry Stabb — DATE SIGNED: 3-13-98

INSTITUTION REPRESENTATIVE SIGNATURE: Revised NOT required amount out of seg. — DATE SIGNED: 3-13-98

DISTRIBUTION: Original - Social Service Case File; Copy - Inmate; Copy - Work/School Supervisor; Copy - Institution/Security

HIRSP
HFS 119

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

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

Analysis Prepared by the Department of Health and Family Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORDER

Pursuant to authority vested in the Department of Health and Family Services by ss. 149.11, 149.12 (3) (c), 149.143 (2) (a) 2., 3. and 4., (3) (a) and (4), 149.144, 149.146 (2) (b) (intro.), 149.15 (5) and 149.17 (4), Stats., as affected by 1997 Wisconsin Act 27, and s. 9123 (4) of 1997 Wisconsin Act 27, the Department of Health and Family Services hereby repeals and recreates rules interpreting ch. 149, Stats., as affected by 1997 Wisconsin Act 27, as follows:

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

Chapter HFS 119

HEALTH INSURANCE RISK-SHARING PLAN

HFS 119.01 AUTHORITY AND PURPOSE. This chapter is promulgated under the authority of ss. 149.11, 149.12 (3) (c), 149.143 (2) (a) 2., 3. and 4., (3) (a) and (4), 149.144, 149.146 (2) (b) (intro.), 149.15 (5) and 149.17 (4), Stats., to establish requirements and procedures for the operation of a plan of health insurance coverage for persons who qualify under s. 149.12, Stats., for coverage because they cannot otherwise obtain it. Every insurer in the state offering health insurance is required by s. 149.13, Stats., to share in the operating, administrative and subsidy expenses of the plan.

HFS 119.02 APPLICABILITY. This chapter applies to the department, to the board of governors for the plan, to the plan administrator, to all insurers and to all eligible persons who receive health care coverage through the plan.

HFS 119.03 ESTABLISHMENT OF PLAN AND TITLE. In accordance with s. 149.11, Stats., a plan of health insurance coverage which meets the requirements of ch. 149, Stats., and s. 632.785, Stats., is established. The title of the plan shall be "Health Insurance Risk-Sharing Plan", and shall be referred to in this chapter as the plan.

HFS 119.04 DEFINITIONS. In this chapter:

(1) "Board" means the HIRSP board of governors established under s. 149.15, Stats.

(2) "Coinsurance" means the percentage of the allowed amount for which the HIRSP policyholder is responsible.

(3) " Commissioner" means the commissioner of insurance.

(4) "Creditable coverage" has the meaning specified in s. 149.10 (2j), Stats.

(5) "Deductible" means the amount, which HIRSP otherwise would pay, for which the HIRSP policyholder is responsible.

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

(7) "HIRSP" means the health insurance risk-sharing plan under this chapter

(8) "Insurer" has the meaning specified in s. 149.10 (5), Stats.

(9) "Managed care" means a program operated by an insurerto evaluate each patient's medical needs and to identify the appropriate treatments to meet those needs, with the primary goal of providing cost-effective health care without sacrificing quality of care or access.

(10) "Medicaid" means the medical assistance program operated by the department under ss 49.43 to 49.497, Stats., and chs. HFS 101 to 108.

(11) "Medically necessary" has the meaning specified in s. HFS 101.03 (96m).

(12) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 and 42 CFR subchapter B

(13) "Plan" means HIRSP.

(14) "Plan administrator" means the fiscal agent under s. 49.45 (2) (b) 2., Stats.

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

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

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

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

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

(19) "Resident" has the meaning specified in s. 149.10 (9), Stats.

(20) "Secretary" means the secretary of the department.

HFS 119.05 ELIGIBILITY. The plan administrator shall determine an applicant's eligibility for coverage under the plan in accordance with s. 149.12, Stats., and as follows:

(1) CRITERIA. The plan administrator shall certify as eligible any resident upon written receipt from the plan applicant of evidence that he or she meets any of the eligibility criteria set forth in s. 149.12 (1), Stats.

(2) NON-ELIGIBILITY. (a) Exclusions from eligibility for the plan shall be as set forth in s. 149.12 (2) and (3), Stats.

(b) For purposes of s. 149.12 (2) (b) 1., Stats., a person is considered to have voluntarily terminated coverage under the plan if the policy terminates because of failure to pay the premium unless the grievance committee of the board determines under s. HFS 119.14 (3) that the failure to pay was not intentional.

(3) SPECIAL ELIGIBILITY REQUIREMENTS. Section 149.12 (2) (e), Stats., does not preclude eligibility for coverage under the plan under any of the following conditions:

(a) When the health care benefits plan for which the person is eligible through his or her employer includes a rider excluding coverage for one or more of the person's conditions for more than 12 months or provides more limited coverage than the coverage available to others covered by the employer's plan.

(b) When the person has continued coverage under s. 632.897, Stats., or the federal consolidated omnibus budget reconciliation act of 1985, as amended.

(4) REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the plan administrator is entitled to a review under s. HFS 119.14. A request for review does not stay termination of coverage.

(5) DATE OF ELIGIBILITY. Coverage for a person certified as eligible for the plan begins on the date the plan receives the person's complete application or, at the request of the applicant, within 60 days following that date or, as provided in s. 149.14 (1) (b), Stats., on the date of termination of medical assistance coverage. Any individual anticipating termination under an individual plan or group health insurance policy or any other plan providing coverage similar to that under a health insurance policy, including medical assistance, may seek to establish eligibility for the plan prior to termination of existing coverage in order to maintain continuous coverage to the greatest extent possible.

(6) CREDITABLE COVERAGE. Pursuant to s. Ins 3.70, the method of aggregating creditable coverage for purposes of s. 149.10 (2t) (a), Stats., shall comply with 45 CFR 146.113 (a) (3).

HFS 119.06 PARTICIPATION OF INSURERS. (1) Every insurer shall share in the expenses of the plan as provided in s. 149.13 (2), Stats. In setting premiums under s. HFS 119.07 (6), the department shall not include any subsidies for the reduction of the cost of premiums or of deductibles in the calculation of operating and administrative costs of the plan. The commissioner may waive the assessment for an insurer or any class of insurers for any year when it is determined that the administrative costs of collecting the assessment would exceed the amount of the assessment.

(2) Every insurer shall file a copy of "Wisconsin health insurance risk-sharing plan assessment form," OCI 43-003, with its annual statement filed with the office of the commissioner of insurance.

Note: Copies of OCI 43-003 may be obtained from the Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701.

(3) An insurer who makes an error in the insurer's assessment form that results in an underpayment of assessments to the plan shall file a corrected assessment form with the office of the commissioner of insurance within 30 days after the error is discovered.

(4) An insurer that makes an error in an assessment form that results in an overpayment of assessments to the plan shall, at any time, file a corrected assessment form with the office of the commissioner of insurance. If the overpayment resulted from an assessment form filed in the previous calendar year, the plan shall credit the insurer's next annual assessment under s. 149.13, Stats., for the amount of the overpayment. If the insurer does not owe any amount for the next annual assessment, the plan shall refund the amount of

the overpayment. No credit or refund may be granted for an error in an assessment form filed in any year prior to the previous calendar year.

HFS 119.07 COVERAGE. (1) REQUIREMENTS. The plan shall offer coverage that complies with ss. 149.14 and 149.146, Stats., and this section.

(2) LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Pursuant to s. 149.14 (1), Stats., if an eligible person is also eligible for medicare coverage, the plan shall not pay or reimburse the person for expenses paid by medicare. As required by s.149.14 (2) (b), Stats., the plan offers under sub. (6) (b) and (c) an alternative for an individual eligible for medicare which reduces the benefits payable by the amounts paid under medicare.

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

(4) COVERED EXPENSES. Covered expenses shall be those services and articles enumerated in s. 149.14 (3), Stats., if the services are medically necessary, appropriate and cost effective, as determined by the plan administrator.

(5) EXCLUSIONS. Exclusions from coverage shall comply with s. 149.14 (4), Stats.

(6) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) Compliance with statutes. Premiums, deductibles and coinsurance shall be in compliance with ss. 149.14(5), 149.146, 149.165 and 149.17, Stats.

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

MAJOR MEDICAL PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,512	$1,368	$1,212
19-24	1,512	1,368	1,212
25-29	1,548	1,404	1,248
30-34	1,764	1,584	1,404
35-39	2,004	1,800	1,608
40-44	2,400	2,160	1,908
45-49	3,048	2,736	2,436
50-54	4,020	3,624	3,228
55-59	5,256	4,740	4,212
60+	6,468	5,820	5,172

MAJOR MEDICAL PLAN – Females

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

MEDICARE PLAN – Males

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

MEDICARE PLAN – Females

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

(c) Base rates for calculating premium reductions. 1. The annual base rates for calculating premium reductions under s. HFS 119.12 that are applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's major medical plan are as follows beginning July 1, 1998:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

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

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

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

2. The annual base rates for calculating premium reductions under s. HFS 119.12 that are applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's medicare plan are as follows beginning July 1, 1998:

MEDICARE PLAN – Males
(Base for Reduced Rates)

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

MEDICARE PLAN – Females
(Base for Reduced Rates)

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

(d) Annual premiums for major medical plan policies with $2500 deductible. In accordance with s. 149.146, Stats., an alternative plan of health insurance involving major medical expense coverage is established with a $2,500 deductible. The schedule of annual premiums for coverage under the alternative plan with a $2,500 deductible is as follows beginning July 1, 1998:

ALTERNATIVE MAJOR MEDICAL PLAN – Males

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

ALTERNATIVE MAJOR MEDICAL PLAN – Females

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

(e) Zones. For the purposes of pars. (b), (c) and (d), Zone 1 shall contain all of the Wisconsin zip code areas in which the first 3 digits are 532. Zone 2 shall contain postal zip code areas in which the first 3 digits are 530, 531, 534 and 537. Zone 3 shall contain postal zip code areas not contained in Zones 1 and 2.

(f) Detailed description of how premium rates are set. 1. The department shall have on file an actuarial report detailing the process by which rates were determined.

2. The annual report of the board to the chief clerk of each house of the legislature required by s. 149.15(2), Stats., and s. HFS 119.08 (2) shall include a section describing premium rate-setting in detail. In order to fulfill this requirement, the board may appoint an actuarial committee under the powers granted to the board in s. 149.15 (5), Stats., and s. HFS 119.08 (3) (d).

(7) PREEXISTING CONDITIONS. Preexisting conditions limitations shall conform with s. 149.14 (6), Stats. Determinations of what constitutes a preexisting condition shall be made by the plan administrator.

(8) COORDINATION OF BENEFITS. Benefits shall be coordinated as provided in s. 149.14 (7), Stats.

(9) RIGHT TO REVIEW. Any person whose claim is denied or reduced by the plan administrator is entitled to a review under s. HFS 119.14.

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

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

(3) BOARD FUNCTIONS. (a) The board shall carry out the functions specified in s. 149.15 (3), Stats., and any other function specified for the board in this chapter.

(b) The board may carry out the functions authorized in s. 149.15 (4), Stats.

(c) The board may provide for agent commissions and require agents and companies to provide assistance in filing applications.

(d) The board may establish subcommittees and appoint members who do not serve on the board to the subcommittees.

HFS 119.09 PLAN ADMINISTRATOR. The plan administrator shall carry out the functions under s. 149.16 (3), Stats., and any other function of the plan administrator specified in this chapter.

HFS 119.10 NOTIFICATION BY INSURERS OF AVAILABILITY OF HIRSP. (1) WHEN NOTICE REQUIRED. If an insurer takes one or more of the actions enumerated in s. 632.785 (1), Stats., the insurer shall notify all persons covered or to be covered by the policy, including parents and guardians in cases involving minor children and individuals adjudged incompetent under ch. 880, Stats., of the existence of HIRSP, as well as the eligibility requirements and how to apply for coverage under the plan, as required by s. 632.785 (1), Stats.

(2) FORM OF NOTICE. An insurer who takes one or more of the actions under s. 632.785 (1), Stats., shall satisfy the notice requirement under sub. (1) by providing each person covered or to be covered by the policy with a copy of "Wisconsin Health Insurance Risk-Sharing Plan (HIRSP)," an informational pamphlet prepared by the department.

Note: Copies of the informational pamphlet may be obtained from EDS, Health Insurance Risk-Sharing Plan (HIRSP), Suite #18, 6406 Bridge Road, Madison, Wisconsin 53784-0018 (phone 608-221-4551 or 1-800-828-4777).

(3) STATEMENT OF REASONS FOR REJECTING, TERMINATING OR CANCELING COVERAGE OR IMPOSING UNDERWRITING RESTRICTIONS. If an insurer rejects, terminates or cancels coverage or imposes underwriting restrictions under 632.785 (1), Stats., the insurer is obligated under s. 632.785 (2), Stats., to include in the notice required under sub. (1) a statement giving the specific medical reasons for the insurer's action.

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

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

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

HFS 119.12 PREMIUM AND DEDUCTIBLE REDUCTIONS FOR LOW-INCOME POLICYHOLDERS. (1) PURPOSE. The purpose of this section is to interpret and implement ss. 149.14 (5) and 149.165, Stats.

(2) ELIGIBILITY. Applicants for coverage under the plan may apply for the reductions under this section. Persons covered under the plan shall reapply annually.

(3) CALCULATION OF PREMIUM AND DEDUCTIBLE REDUCTIONS. (a) The base rates for calculating premium reductions under s. 149.165 (1) and (2), Stats., are set forth in s. HFS 119.07 (6) (c).

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

(c) The plan administrator may reassess the household income of an eligible person at any time during the term of the person's policy. If an eligible person's household income changes during a policy term, the plan administrator may, if appropriate under s. 149.165 (2), Stats., revise the premium for the person in conformity with s. 149.165 (2), Stats., and the deductible for the person under s. 149.14(5) (a), Stats., for the remainder of the policy term. The revised premium and deductible shall take effect the first month beginning after the plan administrator's decision.

(d) The availability of premium and deductible reductions is based on the availability of funds appropriated under s. 20.435 (5) (ah), Stats., including the provisions of s. 149.144, Stats.

(4) APPLICATION FOR PREMIUM AND DEDUCTIBLE REDUCTIONS. An application for premium and deductible reductions is not complete until a Supplemental Application for Premium and Deductible Reduction form or a completed Wisconsin Homestead Credit Schedule H is submitted to the plan administrator. A complete application for premium and deductible reduction may also need to include a completed federal profit or loss from farming form, schedule F. An application for the premium and deductible reduction shall be accompanied by or preceded by an application to the plan.

Note: A person may obtain the supplemental application for premium and deductible reductions at no charge from EDS, Health Insurance Risk-Sharing Plan (HIRSP), 6406 Bridge Road, Suite #18, Madison, Wisconsin 53784-0018 (phone 608-221-4551 or 1-800-828-4777.)

(5) APPLICATION DEADLINES, EFFECTIVE DATES OF REDUCTIONS AND REESTABLISHMENT OF ELIGIBILITY. (a) New plan applicants. New plan applicants may request eligibility for the reductions at any of the following times:

1. At the time of plan application. In this case, for purposes of the premium reduction, the plan administrator shall make the appropriate adjustments regarding the applicant's initial premium payment submitted with the application. Deductible reductions take effect upon issuance of the policy.

2. After eligibility for the plan is established. a. If eligibility for the premium reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of the reduced portion of the premium retroactive to the effective date of the policy. If eligibility for the reduced premium is not established within 31 days after the effective date of the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the renewal date on which it is to take effect, and the plan administrator shall bill the policyholder for the reduced premium beginning on the renewal date.

b. If eligibility for the deductible reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of a portion of the deductible paid by the policyholder prior to establishing eligibility. The amount of the refund shall be the difference between the deductible paid by the policyholder and the deductible as reduced by any reduction to which the policyholder is entitled. If eligibility is not established within 31 days after the effective date of the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the policy's renewal date, and the deductible reduction shall take effect on January 1 of the year commencing after the policy's renewal date.

(b) Existing policy holders. 1. Persons who are existing policyholders as of March 31 shall apply annually by May 1 in order to be eligible for the reductions for the year beginning on July 1.

2. For premium reductions, if the application is not postmarked by May 1, then the application shall be postmarked at least 60 days prior to the policyholder's next policy renewal date in order for the corresponding premium notice to reflect the reduced premium. An existing policyholder who is first determined to be eligible for a premium reduction shall receive a refund on a pro rata basis for the time period between July 1 of each calendar year and the next renewal date.

3. Deductible reductions under this paragraph take place on January 1 of the year following establishment of eligibility.

(c) Under this subsection, the plan administrator shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(d) Reestablisment of eligibility. Eligibility for the premium and deductible reductions shall be reestablished at least annually.

(6) RIGHT TO REVIEW. An applicant who is denied a premium or deductible reduction is entitled to a review under s. HFS 119.14.

HFS 119.13 COST CONTAINMENT PROVISIONS. HIRSP may use common, current methods employed by managed care programs and the medicaid program to contain costs, including prior authorization and other limitations regarding healthcare utilization and reimbursement. When a new policy is issued, the plan administrator shall send the new policyholder a written description of the plan's cost containment provisions and the procedures that the policyholder shall follow in order to comply with these cost containment provisions. The plan administrator shall send existing policyholders a written description of any change to the plan's cost containment provisions or the procedures that policyholders shall follow in order to comply with these cost containment provisions. The existing policyholders shall receive this written description at least 60 days before the change takes effect.

HFS 119.14 GRIEVANCE PROCEDURE. (1) PURPOSE. This section implements s. 149.17 (3), Stats.

(2) REVIEW BY PLAN ADMINISTRATOR. A person entitled under this chapter to a review of a determination by the plan administrator shall, within 60 days of the date of the letter of determination, submit a written request to the plan administrator that the determination be reviewed. Upon receipt of a request, the plan administrator shall review the original determination, either affirm, modify or rescind it and provide the requester with a written response which includes the plan administrator's final decision and the reason for it. The plan administrator shall have 10 days from receipt of a request for review to issue a letter of decision or a letter to the requester asking for additional information.

Note: To request a review by the plan administrator, write: EDS-HIRSP, 6406 Bridge Road, Suite #18, Madison, WI 53784-0018.

(3) REVIEW BY GRIEVANCE COMMITTEE OF THE BOARD. (a) If a decision under sub. (2) is adverse to an applicant or policyholder, the applicant or policyholder may request a review of the decision by the grievance committee of the board. A request for review under this subsection shall be made in writing to the board within 30 days of the date of the letter of decision under sub. (2) and shall clearly describe the reason the requester believes the plan administrator's decision is erroneous under ch. 149, Stats., this chapter or the terms of the plan policy.

Note: To request a review by the grievance committee of the board, write: HIRSP Board Grievance Committee, P.O. Box 309, Madison, WI 53701-0309.

(b) The board shall appoint a grievance committee of at least 5 persons, a majority of whom are not members of the board, to review decisions of the plan administrator that

adversely affect applicants and policyholders entitled to review under this chapter. Upon the written request of an applicant for HIRSP or a policyholder, the grievance committee shall conduct a review based on written submissions by the plan administrator and the applicant or policyholder. No discovery is permitted. The grievance committee may invite or permit representatives of the plan administrator and the applicant or policyholder to appear and make oral statements during the review. The grievance committee shall, within 45 days from the receipt of the applicant's or policyholder's request for review, issue a written decision affirming, modifying or rescinding the decision of the plan administrator and stating the reason for its decision. The committee's decision shall be final, unless the secretary of the department deems a different decision is in the best interests of the state of Wisconsin.

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

(4) RESPONSIBILITY OF PLAN ADMINISTRATOR. The plan administrator shall comply with the final decision of the board's grievance committee or the secretary.

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

(2) INSURER ASSESSMENTS. The insurer assessments for the time period July 1, 1998 through December 31, 1998 total $ 4,266,874.

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

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

Wisconsin Department of Health and
Family Services

Dated: June 25, 1998

By: 
Joseph Leean
Secretary

SEAL:

1997 Session

FISCAL ESTIMATE
DOA-2048 N(R10/96)

☒ ORIGINAL ☐ UPDATED
☐ CORRECTED ☐ SUPPLEMENTAL

LRB or Bill No./Adm. Rule No.
HFS 119

Amendment No. if Applicable

Subject

HEALTH INSURANCE RISK-SHARING PLAN (HIRSP)

Fiscal Effect

State: ☐ No State Fiscal Effect

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

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

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

☐ Decrease Costs

Local: ☐ No local government costs

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

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

Affected Ch. 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

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

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

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

Long-Range Fiscal Implications

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