1999 DRAFTING REQUEST

Bill

Received: **09/30/98**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Administration-Budget 7-9546**

By/Representing: **Jablonsky**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Topic:

DOA:.....Jablonsky - Changes to the Health Insurance Risk-Sharing Plan

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 10/5/98	gilfokm 10/7/98		_____ _____			State
/P1			ismith 10/8/98	_____ _____	lrb_docadmin 10/8/98		State
/P2	kahlepj 12/11/98	gilfokm 12/17/98	jfrantze 12/18/98	_____ _____	lrb_docadmin 12/18/98		State
/1	kahlepj 01/29/99	gilfokm 01/29/99	hhagen 01/31/99	_____ _____	lrb_docadmin 01/31/99		State
/2	kahlepj 01/31/99	jgeller 01/31/99	jfrantze 01/31/99	_____ _____	lrb_docadmin 01/31/99		

FE Sent For:

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/P1			ismith 10/8/98	_____ _____	lrb_docadmin 10/8/98		State
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LRB-0412

1999 DRAFTING REQUEST

Bill

Received: **09/30/98**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Administration-Budget 7-9546**

By/Representing: **Jablonsky**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Topic:

DOA:.....Jablonsky - Changes to the Health Insurance Risk-Sharing Plan

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Instructions:

See Attached

Drafting History:

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/?	kahlepj 10/5/98	gilfokm 10/7/98		_____ _____			State
/P1			ismith 10/8/98	_____ _____	lrb_docadmin 10/8/98		State
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<END>

LRB-0412

1999 DRAFTING REQUEST

Bill

Received: **09/30/98**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Administration-Budget 7-9546**

By/Representing: **Jablonsky**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Topic:

DOA:.....Jablonsky - Changes to the Health Insurance Risk-Sharing Plan

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 10/5/98	gilfokm 10/7/98		_____ _____			State
/P1		/p2-12-17 kmg	ismith 10/8/98	_____ _____	lrb_docadmin 10/8/98		

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LRB-0412

1999 DRAFTING REQUEST

Bill

Received: **09/30/98**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Administration-Budget 7-9546**

By/Representing: **Jablonsky**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Topic:

DOA:.....Jablonsky - Changes to the Health Insurance Risk-Sharing Plan

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj	/P1-10-7 KMG	IS 10/8	IS/KM 10/8	(yes)		

FE Sent For:

<END>

DHFS

Department of Health and Family Services
1999-2001 Biennial Budget Statutory Language Request
September 11, 1998

Statutory Changes to Chapter 149

Current Language

The Health Insurance Risk Sharing Plan (HIRSP) was created in 1979 as a health insurance program for Wisconsin Residents, under age 65, who are considered medically uninsurable due to an adverse health history. Eligibility requirements include but are not limited to submission of a rejection or cancellation notice for health insurance coverage, a notice of greatly increased premiums, decreased coverage from a private insurance company or a positive test for the presence of HIV. Coverage is available in three plans. Plan 1 and Plan 2 provides primary health insurance coverage with a $1,000 and a $2,500 deductible respectively. Plan 3 provides coverage for persons that are eligible for Medicare. State subsidies are available to assist low-income policyholders by reducing their premium payments if they meet certain financial guidelines.

Effective 01/01/98 the administration of HIRSP was transferred from the Office of the Commissioner of Insurance to the Department to utilize the Medicaid cost containment policies and procedures. Payment for the operating and administrative costs of the plan are funded through policyholder premiums, insurance assessments, provider payment rate reductions, and state GPR.

Proposed Change

The following technical changes to current HIRSP Wis. Stats. are needed to be consistent with Health Insurance Portability and Accountability Act (HIPAA) requirements and/or existing HIRSP policy

1. Currently s.149.12 (2) (d) states that except for a person who is an eligible individual, no person who is 65 years or older is eligible for coverage under the plan.

   Change statutory language to state that **149.12(2)(d)(1): not withstanding 149.12(2)(d) if a person is enrolled in HIRSP, the day they turn 65, the person can continue to be eligible for coverage under the plan and can be cancelled only for nonpayment of premiums.**

   HIRSP has been defined as an *individual* health insurance policy by OCI. The definition of eligible individual would exclude existing policyholders because they do not have 18 months of coverage with the most recent *group* coverage. Therefore, according to the statutes existing policyholders that turn 65 would no longer be eligible for HIRSP coverage. HIPAA,

does 632.7495 apply to HIRSP?

however, requires that individual health insurance policies must be guaranteed renewable and can be cancelled only for nonpayment of premiums or fraud.

2. Currently, the exclusions to covered expenses in s.149.14 (4)(g) lists dental care except as provided in sub (3) (m).

   Revise language to specify that s.149.14 (4)(g) lists dental care except as provided in sub (3) (m) **& (3) (q).**

   Existing policy excludes dental services with the exception of (3) (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. The addition of (3) (q) health insurance coverage, only to the extent required under subch. VI of ch. 632, as an exemption to the exclusions of expenses is a technical change, which allows the program to comply with the required s. 632.895 (11) mandatory coverage for treatment for the correction of temporomandibular disorders.

3. Currently, s.149.14 (5) (c) deductible and coinsurance section states that if the aggregate of the covered costs not paid by the plan 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 ceiling are exceeded.

   Revise language to specify that existing policy includes an alternate plan with a $2,500 deductible. If the aggregate of the covered costs not paid by the plan and the deductible exceeds $500 for an eligible person receiving Medicare, $2,000 for an eligible person (with a $1,000 deductible) and $3,500 for an eligible person (with a $2,500 deductible) during a calendar year the plan shall pay 100% of all covered costs incurred by the eligible person during the calendar year after the payment ceiling are exceeded. The out-of-pocket family maximum includes all amounts applied to deductible and coinsurance for a family within a calendar year and should be modified to reflect not only the $4,000 (for families with $1,000 deductibles) but $7,000 (for families with $2,500 deductibles).

is this "choice of coverage" at 149.146?

Desired Effective Date:	Upon Passage
Agency:	DHFS
Agency Contact:	Richard T. Chao
Phone:	267-0356

149.14(5)

(5) Deductibles and coinsurance.

149.14(5)(a)

(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), the deductible shall be $500. For eligible persons under s. 149.165 (2) (b), the deductible shall be $600. For eligible persons under s. 149.165 (2) (c), the deductible shall be $700. For eligible persons under s. 149.165 (2) (d), 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.

149.14(5)(b)

(b) Except as provided in par. (c), 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.

149.14(5)(c)

(c) 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.

149.14(5)(d)

(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).

(1)
deductible:

	low income	all others
medicare eligible	$500	$1000
same as medicare	$600	
	$700	
	$800	

(2)
plan pay 100%:

aggregate ~~of~~ 20% + deductible:

$500 — $2000 or $1000 for all fam. members eligible

add to (1) $2500

(2) ~~$~~ 3,500 , $700 family

D-note

(1) assumed

(2) → ~~Medicare~~ medicare eligible person w/ ~~co~~ coverage under the alternate plan would have same terms as under reg plan

(2) what if members of a family do not have coverage under same "plans"?

(3) may want diff initial ops

State of Wisconsin
1999 - 2000 LEGISLATURE

LRB-0412/1 PI
PJK...:.../... kmg

DOA:.....Jablonsky – Changes to the Health Insurance Risk–Sharing Plan

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

D-note Coon (10-5) do not gmcat

WPD: print w/ line #15

AN ACT ...; **relating to:** the health insurance risk–sharing plan.

Analysis by the Legislative Reference Bureau

Insert A →

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

SECTION 1. 149.12 (2) (d) of the statutes is renumbered 149.12 (2) (d) 1. and amended to read:

149.12 **(2)** (d) 1. Except ~~for a person who is an eligible individual~~ as provided in subd. 2., no person who is 65 years of age or older is eligible 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.

SECTION 2. 149.12 (2) (d) 2. of the statutes is created to read:

149.12 **(2)** (d) 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.

SECTION 3. 149.14 (4) (g) of the statutes is amended to read:

149.14 **(4)** (g) Dental care except as provided in sub. (3) (m) and (q).

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. 3026e, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

SECTION 4. 149.146 (2) (am) of the statutes is created to read:

149.146 **(2)** (am) 1. For eligible persons receiving medicare, the deductible for coverage under this section shall be equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. For all other eligible persons, the deductible for coverage under this section shall be $2,500. 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.

2. Except as provided in subd. 3., 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. If the aggregate of the covered costs not paid by the plan under subd. 2. and the deductible exceeds $500 for an eligible person receiving medicare, $3,500 for any other 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).

SECTION 9322. Initial applicability; health and family services.

(1) ELIGIBILITY FOR COVERAGE UNDER THE HEALTH INSURANCE RISK–SHARING PLAN. The renumbering and amendment of section 149.12 (2) (d) of the statutes and the creation of section 149.12 (2) (d) 2. of the statutes (with respect to a person who has coverage under the health insurance risk–sharing plan when he or she attains age 65) first apply to persons who attain age 65 on the effective date of this subsection.

(2) COVERAGE OF DENTAL CARE UNDER THE HEALTH INSURANCE RISK–SHARING PLAN. The treatment of section 149.14 (4) (g) of the statutes first applies to policies issued or renewed on the effective date of this subsection.

(END)

INSERT A

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The health insurance risk–sharing plan (HIRSP) provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for HIV and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons (called "eligible individuals") who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. HIRSP offers its enrollees an annual choice of coverage under one of two plans, the regular plan and the alternate plan. Responsibility for administering HIRSP is split between the department of health and family services (DHFS) and a board of governors.

The bill makes various changes to current law as it relates to HIRSP. A person who is 65 years of age is not eligible for HIRSP coverage. This provision does not apply, however, to eligible individuals. The bill adds another exception. A person who has HIRSP coverage on the date on which he or she attains age 65 does not lose eligibility for coverage because of his or her age.

HIRSP does not cover dental care except for certain types of oral surgery. In addition, HIRSP covers health care expenses that other insurers are required to cover under the statutes. The bill makes it clear that HIRSP covers treatment for the correction of temporomandibular disorders, which other insurers are required to cover under the statutes, even though the treatment may be considered dental care.

With certain exceptions, the deductible for coverage under HIRSP is $1,000. HIRSP pays 80% of covered costs exceeding the deductible. After a covered person has paid $2,000 in costs, including the deductible, in a calendar year, HIRSP pays 100% of the covered costs for the remainder of the calendar year. If more than one member of a family has HIRSP coverage, HIRSP pays 100% of covered costs after the family has paid $4,000 in costs. The bill specifies these values for covered persons who have elected coverage under the alternate plan. Under the alternate plan, the deductible is $2,500. HIRSP pays 100% of the covered costs after a covered person has paid $3,500 in costs in a calendar year. For a family with more than one covered person, HIRSP pays 100% of covered costs after the family has paid $7,000 in costs.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

(end of ins A)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/P1dn
PJK...
mg

1. For s. 149.146 (2) (am), I assumed that persons eligible for medicare would have the same deductibles, etc., as those persons eligible for medicare who opt for the coverage offered under s. 149.14. Is this correct?

2. Notice that, for the coverage offered under s. 149.14, covered costs must equal $4,000 for all eligible persons in a family in order for the plan to pay 100%. For the coverage offered under s. 149.146, the covered costs must equal $7,000 for all eligilbe persons in a family. What if eligible persons in a family opt for different coverages? Is this possible? If it is, which amount is used for the plan to cover 100% of costs? Does an eligible family member with coverage under s. 149.14 get all costs paid after the family total is $4,000, while a family member with coverage under s. 149.146 gets all costs paid after the total reaches $7,000? Thus, the costs up to $4,000 reflect costs incurred by both family members, while the remaining $3,000 in costs reflect costs incurred by only the second family member?

3. You may want to change the initial applicabilities that I have provided. Do you want to specify an initial applicability for s. 149.146 (2) (am)?

4. Read my analysis closely. Is dividing HIRSP into a regular and an alternate plan an acceptable way of expressing the choice of coverage?

Pamela J. Kahler
Senior Legislative Attorney
266–2682

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/P1dn
PJK:kmg:ijs

October 8, 1998

1. For s. 149.146 (2) (am), I assumed that persons eligible for medicare would have the same deductibles, etc., as those persons eligible for medicare who opt for the coverage offered under s. 149.14. Is this correct?

2. Notice that, for the coverage offered under s. 149.14, covered costs must equal $4,000 for all eligible persons in a family in order for the plan to pay 100%. For the coverage offered under s. 149.146, the covered costs must equal $7,000 for all eligible persons in a family. What if eligible persons in a family opt for different coverages? Is this possible? If it is, which amount is used for the plan to cover 100% of costs? Does an eligible family member with coverage under s. 149.14 get all costs paid after the family total is $4,000, while a family member with coverage under s. 149.146 gets all costs paid after the total reaches $7,000? Thus, the costs up to $4,000 reflect costs incurred by both family members, while the remaining $3,000 in costs reflect costs incurred by only the second family member?

3. You may want to change the initial applicabilities that I have provided. Do you want to specify an initial applicability for s. 149.146 (2) (am)?

4. Read my analysis closely. Is dividing HIRSP into a regular and an alternate plan an acceptable way of expressing the choice of coverage?

Pamela J. Kahler
Senior Legislative Attorney
266–2682

for 0412

DHCF RESPONSES TO LRB HIRSP QUESTIONS

1. For s. 149.146 (2) (am), I assumed that persons eligible for Medicare would have the same deductibles, etc., as those persons eligible for Medicare who opt for the coverage offered under s. 149.14. Is this correct?

The choice of coverage (the $2,500 deductible) is only available for non-Medicare policyholders.

2. Notice that, for the coverage offered under s. 149.14, covered costs must equal $4,000 for all eligible persons in a family in order for the plan to pay 100%. For the coverage offered under s. 149.146, the covered costs must equal $7,000 for all eligible persons in a family. What if eligible persons in a family opt for different coverages? Is this possible? If it is, which amount is used for the plan to cover 100% of costs? Does an eligible family member with coverage under s. 149.14 get all costs paid after the family total is $4,000, while a family member with coverage under s. 149.146 gets all costs paid after the total reaches $7,000? Thus, the cost up to $4,000 reflects costs incurred by both family members, while the remaining $3,000 in cost reflects cost incurred by only the second family member?

Families with two or more members enrolled in HIRSP will pay a maximum amount of covered medical expenses in a calendar year. This amount is the family out-of-pocket maximum, which may be satisfied by any combination of deductibles and coinsurance payments. Once a family has exceeded this maximum out-of-pocket expense, HIRSP will pay 100 percent of covered expenses during the remainder of the year.

The out-of-pocket family maximum should represent a combination of the two highest individual deductibles even if the family includes three members. Some examples would be:

Individual maximum policyholder 1 $2,000
Individual maximum policyholder 2 $3,500
Individual maximum policyholder 3 $ 500

Family maximum in the above situation $ 5,500

Individual maximum policyholder 1 $2,000
Individual maximum policyholder 2 $2,000
Individual maximum policyholder 3 $ 500

Family maximum in the above situation $ 4,000

3. You may want to change the initial applicabilities that I have provided. Do you want to specify an initial applicability for 149.146 9209am)?

The Department is confused as far as the implications of this question. Perhaps we could discuss this later.

4. Read my analysis closely. Is dividing HIRSP into a regular and an alternate plan an acceptable way of expressing the choice of coverage?

It would be less confusing if you indicated that two plans are available to eligible persons under HIRSP major medical policy. Plan 1 is available for persons who are not eligible for Medicare with either a $1,000 deductible option or a $2,500 deductible option. Plan 2 is only for persons eligible for Medicare.

Kahler, Pam
From: Jablonsky, Sue [sue.jablonsky@doa.state.wi.us]
Sent: Friday, December 11, 1998 3:36 PM
To: Kahler, Pam
Subject: FW: HIRSP/ADRP stat language request


DOAADRPHirsp.doc

Hord copy to follow-they are so late with this stuff!!

-----Original Message-----
From: Chao, Richard
Sent: Friday, December 11, 1998 2:01 PM
To: Jablonsky, Sue
Subject: HIRSP/ADRP stat language request

Hey Sue:
Here it is. It really is simply adding five words and crossing out one. Sorry
for the late submission. Hang in there and I hope that you enjoy the weekend.
Rich

Richard T. Chao
Budget Section
Department of Health and Family Services
(608) 267-0356
<<DOAADRPHirsp.doc>>

DHFS

Department of Health and Family Services
1997-99 Biennial Budget Statutory Language Request
December 11, 1998

Title: Wis. Stat. 149.12 (3) (b) Mandatory Health Insurance Risk Sharing Plan

Statutory Change Requested

The recommended language change to s.149.12(3)(b) is as follows:

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, ~~or~~ under s. 253.05 for maternal and child health services, or under s. 49.~~486~~ for AIDS/HIV are not ineligible for coverage under the plan by reason of such payments or reimbursements.

The Administrative/Substantive Problem with Current Statute

The current statute does not allow an individual to have a HIRSP policy if the individual's HIRSP deductible or coinsurance costs are covered via a federally or state funded program. Thus, clients enrolled on ADRP (state and federally funded), are not eligible to have insurance coverage with HIRSP. If this coordination of coverage were not allowed, these clients' coverage with HIRSP would be terminated. They would likely turn to Medicaid for coverage and would revert back to the ADRP covering 100% of their prescription cost. Providing Medicaid coverage would be more costly to the Department as these costs would far exceed HIRSP costs.

Rationale for the Change

This statute change is necessary to allow coverage of HIRSP policy deductibles and coinsurance by the ADRP. At the time of the Insurance Premium Subsidy Program expansion, it was the intention to coordinate HIRSP and ADRP benefits to provide comprehensive health care for low-income individuals with HIV disease.

Legislative Fiscal Bureau (LFB) paper #443 (5/5/97) written in support of the 1997-99 biennial budget provides reference to the legislative intent behind the modification of 252.16. The paper addresses the savings to the state Medicaid program that would result and specifically says, "Under the proposal, the insurance program would purchase policies for these individual's through the state's health insurance risk sharing plan."

The statute that authorizes the HIRSP Program at s.149.12 indicates that no person can be eligible for HIRSP for whom coinsurance, deductibles or premiums are being reimbursed or paid

for by a federal or state government agency. This statute was amended in the 1997-99 budget to make an exception for individuals whose premiums were being paid for by the Subsidy Program.

This statute does not make an exception for individuals whose coinsurance and deductibles are being paid for by the ADRP. By oversight, such an exception was not inserted as part of the 1997-99 budget, partly because the Subsidy Program was the focus of statutory amendments for this initiative. However, the content of Subsidy Program and ADRP budget development documents for 1997-99 make clear the intent at all levels to assure a smooth coordination of benefits between HIRSP, ADRP and the Subsidy Program.

Therefore, a technical correction to 149.12 is requested at this time to specify that ADRP coinsurance and deductible payments does not make an individual ineligible for HIRSP. The recommended language change to s.149.12(3)(b) is as follows:

Desired Effective Date:	Upon Passage
Agency:	DHFS
Agency Contact:	Richard T. Chao
Phone:	267-0356

State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–0412/P2
PJK:kmg:ijs

DOA:.....Jablonsky – Changes to the Health Insurance Risk–Sharing Plan

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the health insurance risk–sharing plan.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The health insurance risk–sharing plan (HIRSP) provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for ~~AIDS~~ and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons (called "eligible individuals") who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. HIRSP offers its enrollees an annual choice of coverage ~~under the state plan, the regional plan and the alternate plan~~. Responsibility for administering HIRSP is split between the department of health and family services (DHFS) and a board of governors.

The bill makes various changes to current law as it relates to HIRSP. A person who is 65 years of age is not eligible for HIRSP coverage. This provision does not apply, however, to eligible individuals. The bill adds another exception. A person who has HIRSP coverage on the date on which he or she attains age 65 does not lose eligibility for coverage because of his or her age.

HIRSP does not cover dental care except for certain types of oral surgery. In addition, HIRSP covers health care expenses that other insurers are required to

insert A-1

cover under the statutes. The bill makes it clear that HIRSP covers treatment for the correction of temporomandibular disorders, which other insurers are required to cover under the statutes, even though the treatment may be considered dental care.

With certain exceptions, the deductible for coverage under HIRSP is $1,000. HIRSP pays 80% of covered costs exceeding the deductible. After a covered person has paid $2,000 in costs, including the deductible, in a calendar year, HIRSP pays 100% of the covered costs for the remainder of the calendar year. If more than one member of a family has HIRSP coverage, HIRSP pays 100% of covered costs after the family has paid $4,000 in costs. The bill specifies these values for covered persons ~~who have elected coverage under the alternate plan. Under the alternate plan, the~~ deductible is $2,500. HIRSP pays 100% of the covered costs after a covered person has paid $3,500 in costs in a calendar year. For a family with more than one covered person, HIRSP pays 100% of covered costs after the family has paid $7,000 in costs.

insert A-2

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 149.12 (2) (d) of the statutes is renumbered 149.12 (2) (d) 1. and amended to read:

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

SECTION 2. 149.12 (2) (d) 2. of the statutes is created to read:

149.12 **(2)** (d) 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.

insert 2-10

SECTION 3. 149.14 (4) (g) of the statutes is amended to read:

149.14 **(4)** (g) Dental care except as provided in sub. (3) (m) and (q).

SECTION 4. 149.146 (2) (am) of the statutes is created to read:

insert 2-12

149.146 (2) (am) 1. For eligible persons receiving medicare, the deductible for coverage under this section shall be equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. For all other eligible persons, the deductible for coverage under this section shall be $2,500. 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.

2. Except as provided in subd. 3., 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. If the aggregate of the covered costs not paid by the plan under subd. 2. and the deductible exceeds $2,500 for an eligible person receiving medicare, $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).

SECTION 9323. Initial applicability; health and family services.

(1) ELIGIBILITY FOR COVERAGE UNDER THE HEALTH INSURANCE RISK–SHARING PLAN. The renumbering and amendment of section 149.12 (2) (d) of the statutes and the

creation of section 149.12 (2) (d) 2. of the statutes (with respect to a person who has coverage under the health insurance risk–sharing plan when he or she attains age 65) first apply to persons who attain age 65 on the effective date of this subsection.

(2) COVERAGE OF DENTAL CARE UNDER THE HEALTH INSURANCE RISK–SHARING PLAN. The treatment of section 149.14 (4) (g) of the statutes first applies to policies issued or renewed on the effective date of this subsection.

(END)

D-note

1999–2000 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/P2ins
PJK:kmg:ijs

INSERT A–1

With certain exceptions, a person for whom a premium, deductible or coinsurance amount is paid by any governmental agency is not eligible for HIRSP coverage. Under another statute, DHFS reimburses persons for the cost of drugs for the treatment of infection by human immunodeficiency virus (HIV) and for the treatment of acquired immunodeficiency syndrome (AIDS). The bill provides that a person who receives such a reimbursement is not ineligible for HIRSP coverage by reason of the reimbursement.

(END OF INSERT A–1

INSERT A–2

not eligible for medicare who choose the other coverage option that HIRSP offers. Under the other coverage option, the

(END OF INSERT A–2))

1999–2000 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/P2ins
PJK:kmg:ijs

INSERT 2–10 ✓

SECTION 1. 149.12 (3) (b) of the statutes is amended to read:

149.12 **(3)** (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 ~~or~~, 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.

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 ~~4831~~e; Stats. ~~1997~~ s. 149.12.

(end of ins 2-10)

Insert 2-12 ✓ 1 of 2

Section #. 149.146 (1) (a) of the statutes is amended to read:

149.146 **(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 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.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237.

who are not eligible for medicare

insert 2-12 cont'd 2 of 2

Section #. 149.146 (1) (b) 2. of the statutes is amended to read:

under par. (a)

149.146 **(1)** (b) 2. An eligible person 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.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237.

(end of ins 2-12)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/P2dn
PJK:kmg:ijs

Sue:

This redraft clarifies that only persons who are not eligible for medicare are eligible to elect coverage under s. 149.146. I also eliminated the initial applicability provision related to TMD coverage because that coverage is already being provided under HIRSP. Do you know if persons who are eligible for medicare are eligible for a subsidy under s. 149.165? If they are not (and I really have no basis for assuming that they are not), I should amend s. 149.165 (1) accordingly.

Pamela J. Kahler
Senior Legislative Attorney
266–2682

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/P2dn
PJK:kmg:jf

December 18, 1998

Sue:

This redraft clarifies that only persons who are not eligible for medicare are eligible to elect coverage under s. 149.146. I also eliminated the initial applicability provision related to TMD coverage because that coverage is already being provided under HIRSP. Do you know if persons who are eligible for medicare are eligible for a subsidy under s. 149.165? If they are not (and I really have no basis for assuming that they are not), I should amend s. 149.165 (1) accordingly.

Pamela J. Kahler
Senior Legislative Attorney
266–2682

State of Wisconsin
1999 - 2000 LEGISLATURE

LRB-0412/P2
PJK:kmg:jf

DOA:.....Jablonsky – Changes to the Health Insurance Risk–Sharing Plan

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the health insurance risk–sharing plan.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The health insurance risk–sharing plan (HIRSP) provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV) and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons (called "eligible individuals") who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. HIRSP offers its enrollees who are not eligible for medicare an annual choice of coverage option. Responsibility for administering HIRSP is split between the department of health and family services (DHFS) and a board of governors.

The bill makes various changes to current law as it relates to HIRSP. A person who is 65 years of age is not eligible for HIRSP coverage. This provision does not apply, however, to eligible individuals. The bill adds another exception. A person who has HIRSP coverage on the date on which he or she attains age 65 does not lose eligibility for coverage because of his or her age.

HIRSP does not cover dental care except for certain types of oral surgery. In addition, HIRSP covers health care expenses that other insurers are required to

cover under the statutes. The bill makes it clear that HIRSP covers treatment for the correction of temporomandibular disorders, which other insurers are required to cover under the statutes, even though the treatment may be considered dental care.

With certain exceptions, a person for whom a premium, deductible or coinsurance amount is paid by any governmental agency is not eligible for HIRSP coverage. Under another statute, DHFS reimburses persons for the cost of drugs for the treatment of HIV infection and for the treatment of acquired immunodeficiency syndrome (AIDS). The bill provides that a person who receives such a reimbursement is not ineligible for HIRSP coverage by reason of the reimbursement.

With certain exceptions, the deductible for coverage under HIRSP is $1,000. HIRSP pays 80% of covered costs exceeding the deductible. After a covered person has paid $2,000 in costs, including the deductible, in a calendar year, HIRSP pays 100% of the covered costs for the remainder of the calendar year. If more than one member of a family has HIRSP coverage, HIRSP pays 100% of covered costs after the family has paid $4,000 in costs. The bill specifies these values for covered persons not eligible for medicare who choose the other coverage option that HIRSP offers. Under the other coverage option, the deductible is $2,500. HIRSP pays 100% of the covered costs after a covered person has paid $3,500 in costs in a calendar year. For a family with more than one covered person, HIRSP pays 100% of covered costs after the family has paid $7,000 in costs.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 149.12 (2) (d) of the statutes is renumbered 149.12 (2) (d) 1. and amended to read:

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

SECTION 2. 149.12 (2) (d) 2. of the statutes is created to read:

149.12 **(2)** (d) 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.

SECTION 3. 149.12 (3) (b) of the statutes is amended to read:

149.12 **(3)** (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 ~~or~~, 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.

SECTION 4. 149.14 (4) (g) of the statutes is amended to read:

149.14 **(4)** (g) Dental care except as provided in sub. (3) (m) and (q).

SECTION 5. 149.146 (1) (a) of the statutes is amended to read:

149.146 **(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.

SECTION 6. 149.146 (1) (b) 2. of the statutes is amended to read:

149.146 **(1)** (b) 2. 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.

SECTION 7. 149.146 (2) (am) of the statutes is created to read:

149.146 **(2)** (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 subd. 3., 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. 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).

SECTION 9323. Initial applicability; health and family services.

(1) ELIGIBILITY FOR COVERAGE UNDER THE HEALTH INSURANCE RISK–SHARING PLAN. The renumbering and amendment of section 149.12 (2) (d) of the statutes and the creation of section 149.12 (2) (d) 2. of the statutes (with respect to a person who has coverage under the health insurance risk–sharing plan when he or she attains age 65) first apply to persons who attain age 65 on the effective date of this subsection.

(END)

D-note

insert B-9

s. 149.14 (6) (a) do not apply to a person who reenrolls in the plan under this subsection.

SECTION #. 149.14 (6) (title) of the statutes is created to read:

149.14 **(6)** (title) PREEXISTING CONDITIONS.

(END) insert B-9

D-note

Sue:

This redraft adds a technical correction (the title of s. 149.14(6)) since I can't put it in LRB-1985 anymore.

PJK

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/1dn
PJK:kmg:hmh

Sunday, January 31, 1999

Sue:

This redraft adds a technical correction (the title of s. 149.14 (6)) since I can't put it in LRB–1985 anymore.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: Pam.Kahler@legis.state.wi.us

State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–0412/2
PJK:kmg:hmh
r mis rem

DOA:.....Jablonsky – Changes to the Health Insurance Risk–Sharing Plan

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

now (1-31) D-note

do not go out

AN ACT ...; **relating to:** the health insurance risk–sharing plan.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The health insurance risk–sharing plan (HIRSP) provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV) and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons (called "eligible individuals") who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. HIRSP offers its enrollees who are not eligible for medicare an annual choice of coverage option. Responsibility for administering HIRSP is split between the department of health and family services (DHFS) and a board of governors → (board) ✓

The bill makes various changes to current law as it relates to HIRSP. A person who is 65 years of age is not eligible for HIRSP coverage. This provision does not apply, however, to eligible individuals. The bill adds another exception. A person who has HIRSP coverage on the date on which he or she attains age 65 does not lose eligibility for coverage because of his or her age.

HIRSP does not cover dental care except for certain types of oral surgery. In addition, HIRSP covers health care expenses that other insurers are required to

cover under the statutes. The bill makes it clear that HIRSP covers treatment for the correction of temporomandibular disorders, which other insurers are required to cover under the statutes, even though the treatment may be considered dental care.

With certain exceptions, a person for whom a premium, deductible or coinsurance amount is paid by any governmental agency is not eligible for HIRSP coverage. Under another statute, DHFS reimburses persons for the cost of drugs for the treatment of HIV infection and for the treatment of acquired immunodeficiency syndrome (AIDS). The bill provides that a person who receives such a reimbursement is not ineligible for HIRSP coverage by reason of the reimbursement.

With certain exceptions, the deductible for coverage under HIRSP is $1,000. HIRSP pays 80% of covered costs exceeding the deductible. After a covered person has paid $2,000 in costs, including the deductible, in a calendar year, HIRSP pays 100% of the covered costs for the remainder of the calendar year. If more than one member of a family has HIRSP coverage, HIRSP pays 100% of covered costs after the family has paid $4,000 in costs. The bill specifies these values for covered persons not eligible for medicare who choose the other coverage option that HIRSP offers. Under the other coverage option, the deductible is $2,500. HIRSP pays 100% of the covered costs after a covered person has paid $3,500 in costs in a calendar year. For a family with more than one covered person, HIRSP pays 100% of covered costs after the family has paid $7,000 in costs.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 149.12 (2) (d) of the statutes is renumbered 149.12 (2) (d) 1. and amended to read:

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

SECTION 2. 149.12 (2) (d) 2. of the statutes is created to read:

149.12 **(2)** (d) 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.

SECTION 3. 149.12 (3) (b) of the statutes is amended to read:

149.12 **(3)** (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 ~~or~~, 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.

SECTION 4. 149.14 (4) (g) of the statutes is amended to read:

149.14 **(4)** (g) Dental care except as provided in sub. (3) (m) and (q).

SECTION 5. 149.14 (6) (title) of the statutes is created to read:

149.14 **(6)** (title) PREEXISTING CONDITIONS.

SECTION 6. 149.146 (1) (a) of the statutes is amended to read:

149.146 **(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.

SECTION 7. 149.146 (1) (b) 2. of the statutes is amended to read:

149.146 **(1)** (b) 2. 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.

SECTION 8. 149.146 (2) (am) of the statutes is created to read:

149.146 **(2)** (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 subd. 3., 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. 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).

Insert 4-21

SECTION 9323. Initial applicability; health and family services.

(1) ELIGIBILITY FOR COVERAGE UNDER THE HEALTH INSURANCE RISK-SHARING PLAN. The renumbering and amendment of section 149.12 (2) (d) of the statutes and the creation of section 149.12 (2) (d) 2. of the statutes (with respect to a person who has

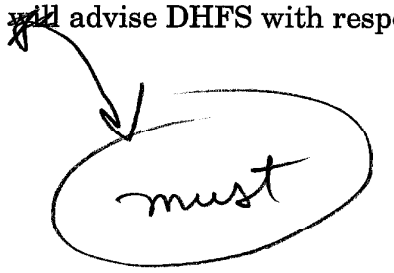
coverage under the health insurance risk–sharing plan when he or she attains age 65) first apply to persons who attain age 65 on the effective date of this subsection.

(END)

INSERT A–2

Finally, the bill changes some of the board's responsibilities, such as establishing procedures for hearing grievances and collecting assessments from insurers, to responsibilities of DHFS. The board ~~will~~ must advise DHFS with respect to those responsibilities.

(END OF INSERT A–2)



insert 3-7

Section #. 149.14 (3) (intro.) of the statutes is amended to read:

and 149.15(3)(e)

149.14 **(3)** COVERED EXPENSES. (intro.) Except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the ~~board under s. 149.15 (3) (e) or by the~~ department under ~~s.~~ 149.143 ~~or~~ 149.144, covered expenses for the coverage under this section shall be the usual and customary charges for the services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the ~~board under s. 149.15 (3) (e) or by the~~ department under ~~s.~~ 149.143 ~~or~~ 149.144, covered expenses for the coverage under this section shall also be the usual and customary charges 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.:

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.

(end of ins 3-7)

insert 4-21 1082

~~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) ~~(b) 2.~~ (bc).

SECTION 22. 149.143 (3m) of the statutes is repealed.

SECTION 23. 149.144 of the statutes is amended to read:

149.144 Adjustments to insurer assessments ~~and provider payment rates~~ for premium and deductible reductions. If the moneys under s. 20.435 (5) (ah) are insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), or the department determines that the moneys under s. 20.435 (5) (ah) will be insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), 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 s. 149.143 (1) ~~(b) 1.~~ (ac), sufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a). The department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

****NOTE: I am somewhat bothered by the "subject to s. 149.143 (1) (ac)" language in this section. Do you think that the cross–reference should instead be to s. 149.143 (1), so that all of the calculations and all of the provisions that include and exclude s. 149.144 are included?

SECTION 24. 149.145 of the statutes is repealed.

SECTION 25. 149.15 (3) (intro.) of the statutes is amended to read:

149.15 **(3)** (intro.) The board shall ~~do~~ advise the department on all of the following:

SECTION 26. 149.15 (3) (a) of the statutes is amended to read:

OVER

ins. 4-21 cont'd 28b 2

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

SECTION 27. 149.15 (3) (c) of the statutes is amended to read:

149.15 **(3)** (c) ~~Collect~~ Determining assessments to be collected 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.

SECTION 28. 149.15 (3) (d) of the statutes is amended to read:

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

Insert 8-16

~~**SECTION 29.** 149.15 (3) (e) of the statutes is repealed.~~

SECTION 30. 149.15 (3) (f) of the statutes is amended to read:

149.15 **(3)** (f) ~~Advise the department on the~~ The choice of coverage under s. 149.146.

***NOTE: Is this amendment okay or should the paragraph be repealed? Even though the "choice of coverage" has been established, ongoing advice concerning it is entirely appropriate.

SECTION 31. 149.16 (1) of the statutes is repealed.

(END) (ins 4-21)

Insert 8-16

Section #. 149.15 (3) (e) of the statutes is amended to read:

Establishing

149.15 **(3)** (e) ~~Establish~~ for payment of covered expenses, a payment rate that is 10% less than the charges approved by the plan administrator for reimbursement of covered expenses under s. 149.14 (3).

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.

(analysis 8-16)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/2dn
PJK:kmg:hmh

jlg

This redraft adds the changes related to the board's responsibilities that were included in LRB–1985. In LRB–1985, s. 149.15 (3) (e) was repealed because of the MA payment rates. In this redraft, I required the board to advise the department on establishing the reduced payment rate under s. 149.15 (3) (e). I hope that is okay.

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0412/2dn
PJK:jlg:jf

January 31, 1999

This redraft adds the changes related to the board's responsibilities that were included in LRB–1985. In LRB–1985, s. 149.15 (3) (e) was repealed because of the MA payment rates. In this redraft, I required the board to advise the department on establishing the reduced payment rate under s. 149.15 (3) (e). I hope that is okay.

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State of Wisconsin
1999 - 2000 LEGISLATURE

LRB–0412/2
PJK:kmg:jf

DOA:.....Jablonsky – Changes to the Health Insurance Risk–Sharing Plan

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the health insurance risk–sharing plan.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The health insurance risk–sharing plan (HIRSP) provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV) and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons (called "eligible individuals") who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. HIRSP offers its enrollees who are not eligible for medicare an annual choice of coverage option. Responsibility for administering HIRSP is split between the department of health and family services (DHFS) and a board of governors (board).

The bill makes various changes to current law as it relates to HIRSP. A person who is 65 years of age is not eligible for HIRSP coverage. This provision does not apply, however, to eligible individuals. The bill adds another exception. A person who has HIRSP coverage on the date on which he or she attains age 65 does not lose eligibility for coverage because of his or her age.

HIRSP does not cover dental care except for certain types of oral surgery. In addition, HIRSP covers health care expenses that other insurers are required to

cover under the statutes. The bill makes it clear that HIRSP covers treatment for the correction of temporomandibular disorders, which other insurers are required to cover under the statutes, even though the treatment may be considered dental care.

With certain exceptions, a person for whom a premium, deductible or coinsurance amount is paid by any governmental agency is not eligible for HIRSP coverage. Under another statute, DHFS reimburses persons for the cost of drugs for the treatment of HIV infection and for the treatment of acquired immunodeficiency syndrome (AIDS). The bill provides that a person who receives such a reimbursement is not ineligible for HIRSP coverage by reason of the reimbursement.

With certain exceptions, the deductible for coverage under HIRSP is $1,000. HIRSP pays 80% of covered costs exceeding the deductible. After a covered person has paid $2,000 in costs, including the deductible, in a calendar year, HIRSP pays 100% of the covered costs for the remainder of the calendar year. If more than one member of a family has HIRSP coverage, HIRSP pays 100% of covered costs after the family has paid $4,000 in costs. The bill specifies these values for covered persons not eligible for medicare who choose the other coverage option that HIRSP offers. Under the other coverage option, the deductible is $2,500. HIRSP pays 100% of the covered costs after a covered person has paid $3,500 in costs in a calendar year. For a family with more than one covered person, HIRSP pays 100% of covered costs after the family has paid $7,000 in costs.

Finally, the bill changes some of the board's responsibilities, such as establishing procedures for hearing grievances and collecting assessments from insurers, to responsibilities of DHFS. The board must advise DHFS with respect to those responsibilities.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 149.12 (2) (d) of the statutes is renumbered 149.12 (2) (d) 1. and amended to read:

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

SECTION 2. 149.12 (2) (d) 2. of the statutes is created to read:

149.12 **(2)** (d) 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.

SECTION 3. 149.12 (3) (b) of the statutes is amended to read:

149.12 **(3)** (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 ~~or,~~ 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.

SECTION 4. 149.14 (3) (intro.) of the statutes is amended to read:

149.14 **(3)** COVERED EXPENSES. (intro.) Except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the ~~board under s. 149.15 (3) (e) or by the~~ department under ~~s.~~ ss. 149.143 ~~or,~~ 149.144 and 149.15 (3) (e), covered expenses for the coverage under this section shall be the usual and customary charges for the services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the ~~board under s. 149.15 (3) (e) or by the~~ department under ~~s.~~ ss. 149.143 ~~or,~~ 149.144 and 149.15 (3) (e), covered expenses for the coverage under this section shall also be the usual and customary charges 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.:

SECTION 5. 149.14 (4) (g) of the statutes is amended to read:

149.14 **(4)** (g) Dental care except as provided in sub. (3) (m) and (q).

SECTION 6. 149.14 (6) (title) of the statutes is created to read:

149.14 **(6)** (title) PREEXISTING CONDITIONS.

SECTION 7. 149.146 (1) (a) of the statutes is amended to read:

149.146 **(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.

SECTION 8. 149.146 (1) (b) 2. of the statutes is amended to read:

149.146 **(1)** (b) 2. 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.

SECTION 9. 149.146 (2) (am) of the statutes is created to read:

149.146 **(2)** (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 subd. 3., 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. 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).

SECTION 10. 149.15 (3) (intro.) of the statutes is amended to read:

149.15 **(3)** (intro.) The board shall ~~do~~ advise the department on all of the following:

SECTION 11. 149.15 (3) (a) of the statutes is amended to read:

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

SECTION 12. 149.15 (3) (c) of the statutes is amended to read:

149.15 **(3)** (c) ~~Collect~~ Determining assessments to be collected 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.

SECTION 13. 149.15 (3) (d) of the statutes is amended to read:

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

SECTION 14. 149.15 (3) (e) of the statutes is amended to read:

149.15 **(3)** (e) ~~Establish~~ Establishing for payment of covered expenses, a payment rate that is 10% less than the charges approved by the plan administrator for reimbursement of covered expenses under s. 149.14 (3).

SECTION 15. 149.15 (3) (f) of the statutes is amended to read:

149.15 **(3)** (f) ~~Advise the department on the~~ The choice of coverage under s. 149.146.

SECTION 9323. Initial applicability; health and family services.

(1) ELIGIBILITY FOR COVERAGE UNDER THE HEALTH INSURANCE RISK–SHARING PLAN. The renumbering and amendment of section 149.12 (2) (d) of the statutes and the creation of section 149.12 (2) (d) 2. of the statutes (with respect to a person who has coverage under the health insurance risk–sharing plan when he or she attains age 65) first apply to persons who attain age 65 on the effective date of this subsection.

(END)