Chapter Ins 18

HEALTH INSURANCE RISK-SHARING PLAN

Ins 18.01 Purpose. This chapter is intended to implement and interpret subch. II of ch. 619, Stats., and s. 632.785, Stats., for the purpose of establishing procedures and requirements for a health insurance risk-sharing plan, in accordance with ss. 619.11 and 601.41 (3), Stats.

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

Ins 18.02 Creation of plan and title. In accordance with ss. 619.11 and 601.41 (3), Stats., a plan of health insurance coverage which meets the requirements of subch. II of ch. 619, Stats., and s. 632.785, Stats., is established. The title of the plan shall be "Health Insurance Risk-Sharing Plan", and shall be referred to in this chapter as the plan.

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

Ins 18.03 Scope. This chapter shall apply to all insurers as defined in s. 619.10 (5), Stats.

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

Ins 18.04 Definitions. For the purpose of this chapter, the definition of terms used shall be those definitions set forth in s. 619.10, Stats.

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

Ins 18.05 Eligibility. Eligibility shall be determined in accordance with s. 619.12, Stats.

(1) CRITERIA. The administering carrier shall certify as eligible any resident as defined in s. 619.10 (9), Stats., upon written receipt from the plan applicant of evidence of any of the eligibility criteria set forth in s. 619.12 (1), Stats., or a physician certification meeting the requirements of sub. (2m) (b) that is accepted following the review process specified under s. 619.12 (2) (e) 2, Stats.

(2) NON-ELIGIBILITY. (a) Exclusions from eligibility for the plan shall be as set forth in s. 619.12 (2), Stats.

(b) For purposes of s. 619.12 (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.

(2m) SPECIAL ELIGIBILITY REQUIREMENTS. Section 619.12 (2) (e) 1., Stats., does not preclude eligibility for coverage under the plan under any of the following conditions:

(a) *Limited coverage under employer plan.* 1. The health care benefits plan for which the person is eligible through his or her employer includes a rider excluding coverage for one or more of the person's conditions for more than 12 months or provides more limited coverage than the coverage available to others covered by the employer's plan.

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

(b) *Physician certification.* 1. An applicant for coverage under the plan who believes he or she is eligible under s. 619.12 (2) (e) 2. a, Stats., shall submit with the application all of the following:

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

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

2. a. Upon receipt of an application under subd. 1, the administering carrier shall notify the insurer named in subd. 1. a that it has the right, under s. 619.123, Stats., to submit information contesting or supporting the physician's certification within 5 working days after receipt of the notice. Only the insurer named in subd. 1. a has the right to support or contest the certification.

b. An insurer which does not respond within the time specified or notifies the administering carrier that it supports the physician's certification may not contest the certification. This does not limit the board's authority to review an application under s. 619.12 (2) (e) 2.

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

d. The board shall make the final decision on the applicant's eligibility for the plan under s. 619.12 (2) (e) 2, Stats. The board may delegate the authority to make the decision to the administering carrier, or may delegate the authority to make the initial decision subject to a right of the applicant or a contesting insurer to appeal an adverse decision to the board.

(3) BOARD REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the administering carrier is entitled to a review by the board under the grievance procedures established by the board under s. 619.15 (3) (a), Stats. Persons denied the premium or deductible reductions under s. Ins 18.12 are entitled to a review under this section.

(4) DATE OF ELIGIBILITY. Except as provided in s. 619.14 (1) (b), Stats., persons certified as eligible for the plan shall be deemed eligible for coverage from the date of application for coverage by the plan. Any individual anticipating termination under an individual plan or group health insurance policy or any other plan providing coverage similar to that under a health insurance policy, including medical assistance, may seek

to establish eligibility for the plan prior to termination of existing coverage, in order to maintain continuous coverage to the greatest extent possible.

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

Ins 18.06 Participation of insurers. Every insurer shall share in the expenses of the plan as provided in s. 619.13 (1) (b), Stats. In setting premiums under s. Ins 18.07 (5), the board of governors shall not include any subsidies for the reduction of the cost of premiums or of deductibles in the calculation of operating and administrative costs of the plan. The commissioner may waive the assessment for an insurer or any class of insurers for any year when it is determined that the administrative costs of collecting the assessment would exceed the amount of the assessment.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. Register, June, 1992, No. 438, eff. 7-1-92.

Ins 18.07 Coverage. Coverage shall conform with s. 619.14, Stats.

(1) LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Limitations on coverage offered shall conform with s. 619.14 (1), Stats. In accordance with s. 619.14 (2) (b), the plan shall offer an alternative to the major medical policy for individuals who are eligible for the plan and also eligible for medicare.

(2) MAJOR MEDICAL EXPENSE COVERAGE. Major medical expense coverage shall conform with s. 619.14 (2), Stats.

(3) COVERED EXPENSES. (a) Covered expenses shall be those services and articles enumerated in s. 619.14 (3), Stats. The formula for determining usual and customary charges shall be developed by the administering carrier and approved by the board.

(b) The plan shall cover services for a chronically mentally ill policyholder in a community support program under s. 619.14 (3) (c) 3, Stats., if the case management review under s. Ins 18.13 (3) (c) determines that the services are medically necessary, appropriate and cost effective.

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