Chapter HSS 138

SUBSIDY OF HEALTH INSURANCE PREMIUMS FOR PERSONS WITH HIV INFECTION

Note: Chapter HSS 138 was created as an emergency rule effective November 21, 1990.

HSS 138.01 Authority and purpose. This chapter is promulgated pursuant to ss. 252.16 and 252.17, Stats., for the purpose of enabling the department to administer a program to subsidize health insurance premium costs for coverage under a group health plan for an individual who takes unpaid medical leave or for continuation coverage available to an individual who is unable to continue his or her employment or must reduce his or her hours because of an illness or medical condition arising from or related to HIV infection.

History: Cr. Register, May, 1991, No. 425, eff. 6-1-91; am. Register, July, 1993, No. 451, eff. 8-1-93; corrections made under s. 13.93 (2m) (b) 7., Stats., Register, August, 1995, No. 476.

HSS 138.02 Applicability. This chapter applies to any individual with HIV infection who is eligible to participate in the subsidy program under this chapter, to the individual's employer, if the individual is currently employed, or former employer, if the individual is no longer employed, to the individual's insurer and to the department.

History: Cr. Register, May, 1991, No. 425, eff. 6-1-91.

HSS 138.03 Definitions. In this chapter:

(1) "Continuation coverage" means coverage under a group health plan that is available under s. 632.897, Stats., 29 USC 1161 to 1168 or 42 USC 300bb-1 to 300bb-8 to a group member upon termination of the group member's employment or a reduction in his or her hours.

(2) "Department" means the Wisconsin department of health and social services.

(3) "Employe" means:

(a) An active or retired wage, commissioned or salaried earner whose services are or were utilized by the employer who is the group policyholder or sponsor of the group health plan and who provided health care coverage to the employe by virtue of the individual's employment; or

(b) A member of a union, trust or association where the union, trust or association is the group policyholder and where the member is entitled to health care coverage by virtue of the individual's membership in the union, trust or association.

(4) "Employer" means a group policyholder subject to s. 632.897, Stats., or the sponsor of a group health plan subject to 29 USC 1161 to 1168 or 42 USC 300bb-1 to 300bb-8, including a controlled group, partnership, or other arrangement under common control, an affiliated service group and employe leasing arrangements.

(5) "Family income" means the gross earnings of an employe and his or her spouse, including wages and salary, net income from non-farm self-employment, net income from farm self-employment, as well as unearned income including social security, dividends, interest income, income from estates or trusts, net rental income or royalties, public assistance, pensions or annuities, unemployment compensation, worker's compensation, maintenance or alimony, child support, family support and veterans' pensions.

(6) "Family size" means the number of individuals in a group of persons related by birth, marriage or adoption who reside together.

(7) "Federal poverty line" means the poverty income threshold by size of family unit for the current calendar year published as part of the poverty income guidelines by the U.S. department of health and human services in the federal register, pursuant to 42 USC 9902 (2).

(8) "Group health plan" means an insurance policy or a partially or wholly uninsured plan or program that provides hospital, medical or other health care coverage to members of a group.

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

(10) "HIV infection" means the pathological state produced by a human body in response to the presence of HIV.

(11) "Insurer" has the meaning prescribed in s. 600.03 (27), Stats.

(12) "Physician" has the meaning prescribed in s. 448.01 (5), namely, an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the medical examining board, and holding a license granted by the medical examining board.

(13) "Residence" means the concurrence of physical presence with intent to remain in a place of fixed habitation, with physical presence being prima facie evidence of intent to remain.

(14) "Substantial reduction in covered health care services" means benefit levels, out-of-pocket expenses, limitations or premiums that are not generally comparable to those of the group policy under which the person was insured when he or she became eligible for continuation coverage and are therefore less advantageous to the person than those of the group policy.

(15) "Unpaid medical leave" means an unpaid leave from employment for an employe who has a serious health condition, as defined in s. 103.10 (1) (g), Stats., which makes the employe unable to perform his or her employment duties.

History: Cr. Register, May, 1991, No. 425, eff. 6-1-91; cr. (15), Register, July, 1993, No. 451, eff. 8-1-93.

HSS 138.04 Participation in the health insurance premium subsidy program. (1) ELIGIBILITY. In order to participate in the health insurance premium subsidy program, a person shall satisfy all of the following requirements which pertain to the type of subsidy the person is seeking:

(a) Have residence in this state;

(b) Have a family income that does not exceed 200% of the federal poverty line for a family the size of the individual's family;

(c) Have an HIV infection;

(d) Except for the right to continued group coverage under s. 632.897, Stats., 29 USC 1161 to 1168 or 42 USC 300bb-1 to 300bb-8, have lost eligibility for group health coverage because employment is terminated or hours reduced due to an illness or medical condition arising from or related to the individual's HIV infection if the person is seeking a subsidy for continuation coverage premiums; and

(e) Is on unpaid medical leave if the person is seeking a subsidy for group health plan premiums while on unpaid medical leave or is eligible for continuation coverage if the person is seeking a subsidy for continuation coverage premiums;

(f) Is not covered by a group health plan other than any of the following:

1. The group health plan under which the individual is covered while on unpaid medical leave or under which the individual is eligible for continuation coverage; or

2. A group health plan that offers a substantial reduction in covered health care services from the group health plan under subd. 1;

(g) Is not covered by an individual health insurance policy other than an individual health insurance policy that offers a substantial reduction in covered health care services from the group health plan under par. (f) 1;

(h) Is not eligible for medicare under 42 USC 1395 to 1395zz; and

(i) Does not have escrowed under s. 103.10 (9) (c), Stats., an amount sufficient to pay the individual's required contribution to his or her group health plan premium payments during an unpaid medical leave if the individual is seeking a subsidy for these payments.

(2) APPLICATION PROCESS. (a) Any individual who satisfies the eligibility conditions under sub. (1) and wants to participate in the health insurance premium subsidy program shall complete and submit to the department an application form, DOH 4614, which shall provide the following information:

1. The individual's name and address;

2. Names of the individual's family members and their ages;

3. Family income information;

4. Name and address of the individual's present or immediate past employer through whom the individual has or had group health coverage and the name and address of the insurer or administrator of the group health plan under which the individual is or was covered;

5. Authorization, in writing, for the department to do all of the following:

a. Contact the individual's employer or former employer or the administrator of the group health plan under which the individual is covered to verify that the individual is on an unpaid medical leave or to verify the individual's eligibility for continuation coverage and the premium and any other conditions of coverage, to make premium payments and for other purposes related to the administration of this chapter; and

b. Make any necessary disclosure to the individual's employer or former employer or the administrator of the group health plan under which the individual is covered regarding the individual's HIV status;

6. Written certification from a physician of the following:

a. That the individual has an HIV infection; and

b. That the individual is on an unpaid medical leave because of an illness or medical condition arising from or related to the individual's HIV infection or because of medical treatment or supervision of the illness or condition or that the individual's employment has been terminated or his or her hours have been reduced because of an illness or medical condition arising from or related to the individual's HIV infection; and

7. Any other information that the department requires for purposes of determining eligibility under sub. (1) or evaluating the health insurance premium subsidy program.

Note: To obtain a copy of DOH 4614, write or phone the Wisconsin Division of Health, AIDS/HIV Program, P.O. Box 309, Madison, WI 53701, (608) 267-5287. The completed form should be returned to the same office.

(b) Any individual who does not satisfy sub. (1) (b), (d) or (e), may submit an application form, DOH 4614, that the department will hold until the individual satisfies all the applicable requirements under sub. (1). The department may not contact the individual's employer or the administrator of the group health plan under which the individual is covered until the individual satisfies all the applicable requirements under sub. (1) unless the individual authorizes the department, in writing, to make that contact and to make any necessary disclosure regarding the individual's HIV infection.

(3) NOTIFICATION OF DECISION. Within 20 working days after receipt by the department of the information described under sub. (2), the department shall determine whether or not the applicant satisfies the conditions under sub. (1) and do one of the following:

(a) If the applicant satisfies all the applicable requirements under sub. (1), the department shall approve the application and notify the applicant in writing; or

(b) If the applicant does not satisfy an applicable requirement under sub. (1), the department shall deny the application and notify the applicant, in writing, of the reasons for denial and of the right under sub. (5) to appeal the denial. If the denial is based upon inability to satisfy one or more of the requirements under sub. (1) (b), (d) or (e), the department shall include in the notice information that the department will hold the application until the applicant submits to the department written documentation that the requirement or requirements not met have been met, without need of the applicant to reapply.

(4) RIGHT TO REAPPLY. If the reasons listed by the department under sub. (3) (b) for denial change, an applicant may reapply.

(5) RIGHT TO APPEAL. In the event that the department denies an application, the applicant may request a hearing under ch. 227, Stats. The request for a hearing shall be submitted, in writing, to the department's office of administrative hearings and received by that office no later than 20 calendar days after the date of the letter of denial under sub. (3) (b).

Note: The mailing address of the Office of Administrative Hearings is P.O. Box 7875, Madison, WI 53707.

History: Cr. Register, May, 1991, No. 425, eff. 6-1-91; am. (1) (intro.), (d) to (f) 1., (2) (a) (intro.), 5. a. and b., 6. b., 7., (b), (3) (a) and (b), r. and recr. (1) (i), Register, July, 1993, No. 451, eff. 8-1-93.

HSS 138.05 Payment of health insurance premiums. (1) AMOUNT AND PERIOD OF SUBSIDY. (a) Except as provided in pars. (e), (f) and (g), if an individual satisfies s. HSS 138.04 (1) and has been notified by the department under s. HSS 138.04 (3) (a) that the application has been approved, the department shall pay the full amount of each premium payment for coverage under a group health plan during an unpaid medical leave or for continuation coverage that is due from the individual on or after the date of the notice of decision under s. HSS 138.04 (3).

(b) The department may not refuse to pay the full amount of each premium payment because the group health plan coverage during an unpaid medical leave or continuation coverage that is available to the individual who satisfies s. HSS 138.04 (1) includes coverage of the individual's spouse and dependents.

(c) Except as provided in par. (e), the department shall terminate payments when:

1. The individual's unpaid medical leave or continuation coverage ceases;

2. The individual no longer satisfies s. HSS 138.04 (1); or

3. Upon the expiration of 29 months after the unpaid medical leave or continuation coverage began, whichever occurs first.

(d) The department may not make payments under this section for premiums for a conversion policy or plan that is available to an individual under s. 632.897 (4) or (6), Stats., 29 USC 1162 (5) or 42 USC 300bb-2 (5).

(e) The obligation of the department to make payments under this section is subject to the availability of funds in the appropriation under s. 20.435 (1) (ak), Stats.

(f) The amount paid under par. (a) may not exceed the applicable premium as defined in 29 USC 1164 or 42 USC 300bb-4, as amended to April 7, 1986.

(g) If an individual who satisfies s. HSS 138.04 (1) has an amount escrowed under s. 103.10 (9) (c), Stats., that is not sufficient to pay the required contribution to his or her premium payments while on unpaid medical leave, the amount paid under par. (a) may not exceed the individual's required contribution for the duration of the unpaid medical leave minus the amount escrowed.

(2) PAYMENT OF PREMIUMS. The department shall make payment of premiums allowed under sub. (1) to the insurer, the administrator of an employer self-funded plan or the employer that provides the group health plan coverage during an unpaid medical leave or the continuation coverage, or to the covered individual when the individual, in order to meet a premium due date, makes a payment after the department has approved his or her application, if the individual provides the department with proof that the payment was made.

History: Cr. Register, May, 1991, No. 425, eff. 6-1-91; am. (1) (a), (b), (c) 1., 3. and (2), cr. (1) (g), Register, July, 1993, No. 451, eff. 8-1-93.