CHAPTER 149

HEALTH INSURANCE RISK−SHARING PLANS

SUBCHAPTER I

GENERAL PROVISIONS

149.10 Definitions. In this chapter, unless the context requires otherwise:

(1) "Authority" means the Health Insurance Risk−Sharing Plan Authority.

(2) "Board" means the board of directors of the authority.

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

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

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

1. A group health plan.

2. Health insurance.

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

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

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

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

7. A state health benefits risk pool.

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

9. A public health plan.

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

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

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

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

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

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

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

(e) If the individual was offered the option of continuation coverage under a federal continuation provision or similar state program, including under 2009 Wisconsin Act 11, section 9126 (2), the individual elected the continuation coverage.

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

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

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

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

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

(c) Title XXII of P.L. 104−191.

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

(3e) "Fund" means the Health Insurance Risk−Sharing Plan fund under s. 149.11 (2).

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

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

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

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

(3m) "Health care coverage revenue" means any of the following, but does not include payments to health maintenance organizations under s. 49.45 (59) (a):

(a) Premiums received for health care coverage.

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

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

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

(4) "Health insurance" means surgical, medical, hospital, major medical and other health service coverage provided on an expense−incurred basis and fixed indemnity policies. "Health insurance" does not include ancillary coverages such as income continuation, short−term, accident only, credit insurance, automobile medical payment coverage, coverage issued as a supplement to liability coverage, loss of time or accident benefits.

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

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

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

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

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

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

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

(5) "Insurer" means any person or association of persons, including a health maintenance organization, limited service health organization or preferred provider plan offering or insuring health services on a prepaid basis, including, but not limited to, policies of health insurance issued by a currently licensed insurer, as defined in s. 600.03 (27), nonprofit hospital or medical service plans under ch. 613, cooperative medical service plans under s. 185.981, or other entity whose primary function is to provide diagnostic, therapeutic or preventive services to a defined population in return for a premium paid on a periodic basis. "Insurer" includes any person providing health services coverage for individuals on a self−insurance basis without the intervention of other entities, as well as any person providing health insurance coverage under a medical reimbursement plan to persons. "Insurer" does not include a plan under ch. 613 which offers only dental care.

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

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

(7) "Medicare" means coverage under part A, part B, and part D of Title XVIII of the federal social security act, 42 USC 1395 et seq., as amended.

(8) "Plan" means the health care insurance plan established and administered under subchapter II of this chapter.

(8c) "Policy" means any document other than a group certificate used to prescribe in writing the terms of an insurance contract, including endorsements and riders and service contracts issued by motor clubs.

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

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

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

(9) "Resident" means a person who has been legally domiciled in this state for a period of at least 3 months or, with respect to an eligible individual, an individual who resides in this state. For purposes of this chapter, legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this state. A person with a developmental disability or another disability that prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state.

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

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38; 2003 a. 33; 2005 a. 74; 2009 a. 2, 11.

149.105 Immunity. No cause of action of any nature may arise against, and no liability may be imposed upon, the authority, plan, or board; or any agent, employee, or director of any of them; or participating insurers; or the commissioner; or any of the commissioner's agents, employees, or representatives, for any act or omission by any of them in the performance of their powers and duties under this chapter, unless the person asserting liability proves that the act or omission constitutes willful misconduct.

History: 2005 a. 74.

SUBCHAPTER II

HEALTH INSURANCE RISK−SHARING PLAN PROVISIONS

149.11 Administration of plan. (1) AUTHORITY. The authority shall be responsible for the operation of the plan and, subject to ss. 149.43 (2) and 149.47, may enter into contracts for the plan's administration.

(2) FUND. (a) The authority shall pay the operating and administrative expenses of the plan from the fund, which shall be outside the state treasury and which shall consist of all of the following:

1. Insurer assessments under s. 149.13.

2. Premiums paid by eligible persons.

3. Moneys received from the federal government in high risk pool grants.

4. The moneys transferred under 2005 Wisconsin Act 74, section 166 (1).

5. The earnings resulting from investments under par. (b).

6. Any other moneys received by the authority from time to time.

(b) The authority controls the assets of the fund.

(c) Moneys in the fund may be expended only for the purposes specified in par. (a).

History: 1979 c. 313; 1997 a. 27 s. 4825; Stats. 1997 s. 149.11; 2005 a. 74 ss. 41, 42, 77; 2007 a. 20.

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

149.115 Rules relating to creditable coverage. The commissioner shall promulgate rules that specify how creditable

coverage is to be aggregated for purposes of s. 149.10 (2t) (a) and that determine the creditable coverage to which s. 149.10 (2t) (b) and (d) applies. The rules shall comply with section 2701 (c) of P.L. 104−191.

History: 1997 a. 27 s. 4825f; 1997 a. 237; 2001 a. 16; 2005 a. 74.

149.12 Eligibility determination. (1) Except as provided in subs. (1m), (2), and (3), the authority shall certify as eligible a person who is covered by Medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has a positive, validated HIV test result, as defined in s. 252.01 (8); a person who is an eligible individual; and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

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

(am) A notice of cancellation of coverage from one or more insurers.

(b) A notice of reduction or limitation of coverage, including restrictive riders, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

(c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies then in effect.

(d) A notice of premium for a policy not yet in effect from 2 or more insurers which exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage provided by the plan.

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

(2) (b) 1. Except as provided in subd. 2., no person who is covered under the plan and who voluntarily terminates the coverage under the plan is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage under the plan.

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

(c) No person on whose behalf the plan has paid out the lifetime limit under s. 149.14 (2) (a) or more is eligible for coverage under the plan.

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

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

a. A person who is an eligible individual.

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

(e) 1. Subject to subd. 2., no person who is eligible for creditable coverage, other than those benefits specified in s. 632.745 (11) (b) 1. to 12., that is provided by an employer on a self−insured basis or through health insurance is eligible for coverage under the plan.

2. The board may specify, subject to the approval of the commissioner, other types of coverage provided by an employer that do not render a person ineligible for coverage under the plan.

(f) 1. Except as provided in subd. 2., no person who is eligible for medical assistance is eligible for coverage under the plan.

2. Subdivision 1. does not apply to a person who is otherwise eligible for coverage under the plan and who is eligible for only any of the following types of medical assistance:

a. Family planning services under s. 49.45 (24r) .

NOTE: Section 49.45 (24r) was repealed by 2011 Wis. Act 32.

b. Care and services for the treatment of an emergency medical condition under 42 USC 1396b (v), as provided in s. 49.45 (27).

c. Medical assistance under s. 49.46 (1) (a) 15.

d. Ambulatory prenatal care under s. 49.465.

e. Medicare premium, coinsurance, and deductible payments under s. 49.46 (2) (c) 2. or 3., 49.468 (1) (b) or (c), or 49.47 (6) (a) 6. b. or c.

f. Medicare premium payments under s. 49.46 (2) (cm), 49.468 (1m) or (2), or 49.47 (6) (a) 6m.

g. Benefits under the demonstration project for childless adults under s. 49.45 (23).

h. Benefits under BadgerCare Plus under s. 49.471 (11).

(g) A person is not eligible for coverage under the plan if the person is eligible for any of the following:

1. Services under s. 46.27 (11), 46.275, 46.277, or 46.278.

2. Medical assistance provided as part of a family care benefit, as defined in s. 46.2805 (4).

3. Services provided under the disabled children's long−term support program, as defined in s. 46.011 (1g).

4. Services provided under the program of all−inclusive care for the elderly under s. 49.45 (58).

5. Services provided under the demonstration program under a federal waiver authorized under 42 USC 1315.

6. Health care coverage under the Badger Care health care program under s. 49.665.

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

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

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

(c) Persons for whom premium costs for health insurance coverage and copayments for certain prescription drugs are paid under the pilot program under s. 49.686 (6) are not ineligible for coverage under the plan by reason of such payments.

(4) Subject to subs. (1m), (2), and (3), the authority may establish criteria that would enable additional persons to be eligible for coverage under the plan. The authority shall ensure that any expansion of eligibility is consistent with the purpose of the plan to provide health care coverage for those who are unable to obtain health insurance in the private market and does not endanger the solvency of the plan.

(5) The authority shall establish policies for determining and verifying the continued eligibility of an eligible person.

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12; 1999 a. 9; 2005 a. 74; 2007 a. 20, 39, 141; 2009 a. 28, 83, 84, 209.

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

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

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

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

(4) Notwithstanding subs. (1) to (3), the authority, with the agreement of the commissioner, may perform various administrative functions related to the assessment of insurers participating in the cost of administering the plan. Neither the commissioner nor the authority may assess any type of insurance that was not being assessed as of December 1, 2005, or any type of insurer that was not being assessed as December 1, 2005.

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269; 1997 a. 27 ss. 4834 to 4838; Stats. 1997 s. 149.13; 2001 a. 16; 2005 a. 74; 2007 a. 20.

149.14 Coverage. (1) COVERAGE OFFERED. (a) The plan shall offer coverage for each eligible person in an annually renewable policy. If an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid for by Medicare. If an eligible person is eligible for a type of medical assistance specified in s. 149.12 (2) (f) 2., the plan shall not pay or reimburse the person for expenses paid for by Medical Assistance.

(b) If an individual terminates medical assistance coverage and applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 149.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of medical assistance coverage.

(2) MAJOR MEDICAL EXPENSE COVERAGE. (a) The plan shall provide every eligible person who is not eligible for Medicare with major medical expense coverage. Major medical expense coverage offered under the plan under this section shall pay an eligible person's covered expenses, subject to deductible, copayment, and coinsurance payments, up to a lifetime limit per covered individual of $1,000,000 or a higher amount, as determined by the authority.

(b) The plan shall provide an alternative policy for those persons eligible for medicare which reduces the benefits payable under par. (a) by the amounts paid under medicare.

(c) In addition to the coverage under pars. (a) and (b), 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. An eligible person who is not eligible for Medicare may elect once each year, at the time and according to procedures established by the authority, among the coverages offered under this paragraph and par. (a). 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 the plan. 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 the plan and the person remained continuously covered under the plan up to the time of electing the new coverage.

(3) COVERED EXPENSES. Covered expenses for coverage under the plan shall be the payment rates established by the authority for services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Covered expenses for coverage under the plan shall also be the payment rates established by the authority for, at a minimum, 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, except for prescription drugs that are provided by a network of pharmacies approved by the board, is provided by a provider certified under s. 49.45 (2) (a) 11.:

(a) Hospital services.

(b) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental.

(c) 1. Inpatient hospital services, as defined in s. 632.89 (1) (d), outpatient services, as defined in s. 632.89 (1) (e), and transitional treatment arrangements, as defined in s. 632.89 (1) (f), at least to the extent required under s. 632.89.

3. Subject to the limits under subd. 1., services for the chronically mentally ill in community support programs operated under s. 51.421.

(d) Drugs requiring a physician's prescription.

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

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

(f) Services of a home health agency, as defined in s. 50.49 (1) (a), only to the extent required under s. 632.895 (2).

(g) Use of radium or other radioactive materials.

(h) Oxygen.

(i) Anesthetics.

(j) Prostheses other than dental.

(k) Rental or purchase, as appropriate, of durable medical equipment or disposable medical supplies, other than eyeglasses and hearing aids.

(L) Diagnostic X−rays and laboratory tests.

(m) Oral surgery for excision of partially or completely unerupted, impacted teeth and oral surgery with respect to the gums and other tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(n) Services of a physical therapist.

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

(o) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition.

(q) Any other health insurance coverage, only to the extent required under subch. VI of ch. 632.

(r) Processing charges for blood including, but not limited to, the cost of collecting, testing, fractionating and distributing blood.

(3c) TEMPORARY PROVIDER CERTIFICATION. Notwithstanding the provider licensing and certification requirements under sub. (3) (intro.), for coverage of services or articles provided to an eligible person the authority may certify on a temporary basis a provider that is not licensed under ch. 446 or 448 but that is licensed in another state to provide the service or article, or a provider that

is not certified under s. 49.45 (2) (a) 11. The certification under this subsection may be retroactive.

(4) PLAN DESIGN. Subject to subs. (1) to (3), (5), and (6), the authority shall establish the plan design, after taking into consideration the levels of health insurance coverage provided in the state and medical economic factors, as appropriate. Subject to subs. (1) to (3), (5), and (6), the authority shall provide benefit levels, deductibles, copayment and coinsurance requirements, exclusions, and limitations under the plan that the authority determines generally reflect and are commensurate with comprehensive health insurance coverage offered in the private individual market in the state. The authority may develop additional benefit designs that are responsive to market conditions.

(5) DEDUCTIBLE AND COPAYMENT SUBSIDIES. (a) The authority shall establish and provide subsidies for deductibles paid by eligible persons with household incomes specified in s. 149.165 (2) (a) to (e).

(b) The authority may provide subsidies for prescription drug copayment amounts paid by eligible persons specified in par. (a).

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

(7) COORDINATION OF BENEFITS. (a) Covered expenses under the plan shall not include any charge for care for injury or disease for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self−insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another policy of health care insurance, medicare, medical assistance or any other governmental program, except as otherwise provided by law.

(b) The authority has a cause of action against an eligible participant for the recovery of the amount of benefits paid that are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(c) The authority is subrogated to the rights of an eligible person to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33; 2005 a. 74 ss. 93 to 122, 130, 131; 2007 a. 39; 2009 a. 83.

149.141 Premiums. (1) PERCENTAGE OF COSTS. Except as provided in sub. (2), the authority shall set premium rates for coverage under the plan at a level that is sufficient to cover 60 percent of plan costs, as provided in s. 149.143 (1).

(2) LIMITATION. In no event may plan premium rates exceed 200 percent of rates applicable to individual standard risks.

History: 2005 a. 74.

149.142 Provider payment rates. (1) ESTABLISHMENT OF RATES. The authority shall establish provider payment rates for covered expenses that consist of the usual and customary payment rates, as determined by the authority, for the services and articles provided plus an adjustment determined by the authority. The adjustments to the usual and customary rates shall be sufficient to cover the portion of plan costs specified in s. 149.143 (1) (c) and (2) (b).

(2m) PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance, or deductibles required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under sub. (1) and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under sub. (1).

History: 1999 a. 9; 2001 a. 16; 2005 a. 74 ss. 111, 124 to 126; 2007 a. 39.

149.143 Payment of plan costs. (1) COSTS EXCLUDING SUBSIDIES. The authority shall pay plan costs, excluding any premium, deductible, and copayment subsidies, first from any federal funds under s. 149.11 (2) (a) 3. that exceed premium, deductible, and copayment subsidy costs in a policy year. The remainder of the plan costs, excluding premium, deductible, and copayment subsidy costs, shall be paid as follows:

(a) Sixty percent from premiums paid by eligible persons.

(b) Twenty percent from insurer assessments under s. 149.13.

(c) Twenty percent from adjustments to provider payment rates under s. 149.142.

(2) SUBSIDY COSTS. The authority shall pay for premium, deductible, and copayment subsidies in a policy year first from any federal funds under s. 149.11 (2) (a) 3. received in that year. The remainder of the subsidy costs shall be paid as follows:

(a) Fifty percent from insurer assessments under s. 149.13.

(b) Fifty percent from adjustments to provider payment rates under s. 149.142.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33; 2005 a. 74; 2007 a. 20.

149.165 Reductions in premiums for low−income eligible persons. (1) The authority shall reduce the premiums established under s. 149.141 for the eligible persons and in the manner set forth in subs. (2) and (3).

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

(a) If equal to or greater than $0 and less than $10,000, by at least 30 percent.

(b) If equal to or greater than $10,000 and less than $14,000, by at least 25 percent.

(c) If equal to or greater than $14,000 and less than $17,000, by at least 20 percent.

(d) If equal to or greater than $17,000 and less than $20,000, by at least 15 percent.

(e) If equal to or greater than $20,000 and less than $25,000, by at least 10 percent.

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

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

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

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

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

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165; 2003 a. 33; 2005 a. 74; 2007 a. 20, 39.

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

(1) Subject to s. 149.143, a rating plan calculated in accordance with generally accepted actuarial principles.

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

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17; 1999 a. 9, 165; 2005 a. 74.

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

History: 1979 c. 313; 1981 c. 314; 1997 a. 27 s. 4902; Stats. 1997 s. 149.18; 2005 a. 74.

SUBCHAPTER III

HEALTH INSURANCE RISK−SHARING PLAN AUTHORITY

149.41 Creation and organization of authority. (1) There is created a public body corporate and politic to be known as the "Health Insurance Risk−Sharing Plan Authority." The board of directors of the authority shall consist of the commissioner of insurance, or his or her designee, as a nonvoting member, and the following members, who shall be nominated by the governor, and with the advice and consent of the senate appointed, for 3−year terms:

(a) Four members who represent insurers participating in the plan.

(b) Four members who represent health care providers, including one representative of the Wisconsin Medical Society, one representative of the Wisconsin Hospital Association, Inc., one representative of the Pharmacy Society of Wisconsin, and one representative of health care providers that provide services to persons with coverage under the plan.

(c) Five other members, at least one of whom represents small businesses that purchase private health insurance, one of whom is a professional consumer advocate who is familiar with the plan, and at least 2 of whom are persons with coverage under the plan.

(2) A vacancy on the board shall be filled in the same manner as the original appointment to the board for the remainder of the unexpired term, if any.

(3) A member of the board may not be compensated for his or her services but shall be reimbursed for actual and necessary expenses, including travel expenses, incurred in the performance of his or her duties.

(4) Annually, the governor shall appoint one member other than the commissioner as chairperson, and the members of the board may elect other officers as they consider appropriate. Seven voting members of the board constitute a quorum for the purpose of conducting the business and exercising the powers of the authority, notwithstanding the existence of any vacancy. The board may take action upon a vote of a majority of the members present, unless the bylaws of the authority require a larger number.

(5) The board may appoint an executive director who shall not be a member of the board and who shall serve at the pleasure of the board. The authority may delegate by resolution to one or more of its members or its executive director any powers and duties that it considers proper. The executive director shall receive such compensation as may be determined by the board. The executive director or other person designated by resolution of the board shall keep a record of the proceedings of the authority and shall be custodian of all books, documents, and papers filed with the authority, the minute book or journal of the authority, and its official seal. The executive director or other person may cause copies to be made of all minutes and other records and documents of the authority and may give certificates under the official seal of the authority to the effect that such copies are true copies, and all persons dealing with the authority may rely upon such certificates.

History: 2005 a. 74.

149.43 Duties of authority. In addition to all other duties imposed under this chapter, the authority shall do all of the following:

(1) Adopt policies for the administration of this chapter.

(2) Contract with the plan administrator under s. 149.16, 2003 stats., in the manner required under 2005 Wisconsin Act 74, section 165 (1) (b) until the end of the contract term.

(3) Establish the authority's annual budget and monitor the fiscal management of the authority.

(4) Beginning on July 1, 2006, do, or contract with another person to do, all of the following:

(a) Perform all eligibility and administrative claims payment functions relating to the plan.

(b) Establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the authority.

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

1. Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made.

2. Evaluating the eligibility of each claim for payment under the plan.

3. Notifying each claimant within 30 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected, or compromised.

(5) Seek to qualify or maintain the plan as a state pharmacy assistance program, as defined in 42 CFR 423.464.

(6) Annually submit a report to the legislature under s. 13.172 (2) and to the governor on the operation of the plan.

History: 2005 a. 74.

149.45 Powers of authority. (1) Except as restricted under sub. (2), the authority shall have all the powers necessary or convenient to carry out the purposes and provisions of this chapter. In addition to all other powers granted by this chapter, the authority may:

(a) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business.

(b) Have a seal and alter the seal at pleasure; have perpetual existence; and maintain an office.

(c) Hire employees, define their duties, and fix their rate of compensation.

(d) Incur debt, except as restricted under sub. (2).

(e) Contract for any professional services required for the authority, subject to ss. 149.43 (2) and 149.47.

(f) Appoint any technical or professional advisory committee that the authority finds necessary to assist the authority in exercising its duties and powers. The authority shall define the duties of the committee, and provide reimbursement for the expenses of the committee.

(g) Execute contracts and other instruments.

(h) Accept gifts, grants, loans, or other contributions from private or public sources.

(i) Procure liability insurance.

(2) The authority may not issue bonds.

History: 2005 a. 74.

149.47 Contracting for professional services. (1) Whenever contracting for professional services, the authority shall solicit competitive sealed bids or competitive sealed proposals, whichever is appropriate. Each request for competitive sealed proposals shall state the relative importance of price and other evaluation factors.

(2) (a) When the estimated cost exceeds $25,000, the authority may invite competitive sealed bids or proposals by publishing a class 2 notice under ch. 985 or by posting notice on the Internet at a site determined or approved by the authority. The notice shall describe the contractual services to be purchased, the intent to make the procurement by solicitation of bids or proposals, any requirement for surety, and the date the bids or proposals will be

opened, which shall be at least 7 days after the date of the last insertion of the notice or at least 7 days after the date of posting on the Internet.

(b) When the estimated cost is $25,000 or less, the authority may award the contract in accordance with simplified procedures established by the authority for such transactions.

(c) For purposes of clarification, the authority may discuss the requirements of the proposed contract with any person who submits a bid or proposal and shall permit any offerer to revise his or her bid or proposal to ensure its responsiveness to those requirements.

(3) (a) The authority shall determine which bids or proposals are reasonably likely to be awarded the contract and shall provide each offerer of such a bid or proposal a fair and equal opportunity to discuss the bid or proposal. The authority may negotiate with each offerer in order to obtain terms that are advantageous to the authority. Prior to the award of the contract, any offerer may revise his or her bid or proposal. The authority shall keep a written record of all meetings, conferences, oral presentations, discussions, negotiations, and evaluations of bids or proposals under this section.

(b) In opening, discussing, and negotiating bids or proposals, the authority may not disclose any information that would reveal the terms of a competing bid or proposal.

(4) (a) After receiving each offerer's best and final offer, the authority shall determine which proposal is most advantageous and shall award the contract to the person who offered it. The authority's determination shall be based only on price and the other evaluation factors specified in the request for bids or proposals. The authority shall state in writing the reason for the award and shall place the statement in the contract file.

(b) Following the award of the contract, the authority shall prepare a register of all bids or proposals.

History: 2005 a. 74.

149.50 Political activities. (1) No employee of the authority may directly or indirectly solicit or receive subscriptions or contributions for any partisan political party or any political purpose while engaged in his or her official duties as an employee. No employee of the authority may engage in any form of political activity calculated to favor or improve the chances of any political party or any person seeking or attempting to hold partisan political office while engaged in his or her official duties as an employee or engage in any political activity while not engaged in his or her official duties as an employee to such an extent that the person's efficiency during working hours will be impaired or that he or she will be tardy or absent from work. Any violation of this section is adequate grounds for dismissal.

(2) If an employee of the authority declares an intention to run for partisan political office, the employee shall be placed on a leave of absence for the duration of the election campaign and if elected shall no longer be employed by the authority on assuming the duties and responsibilities of such office.

(3) An employee of the authority may be granted, by the executive director, a leave of absence to participate in partisan political campaigning.

(4) Persons on leave of absence under sub. (2) or (3) shall not be subject to the restrictions of sub. (1), except as they apply to the solicitation of assistance, subscription, or support from any other employee in the authority.

History: 2005 a. 74.

149.53 Liability limited. (1) Neither the state nor any political subdivision of the state nor any officer, employee, or agent of the state or a political subdivision who is acting within the scope of employment or agency is liable for any debt, obligation, act, or omission of the authority.

(2) All of the expenses incurred by the authority in exercising its duties and powers under this chapter shall be payable only from funds of the authority.

History: 2005 a. 74.