State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-3587/1
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2011 SENATE BILL 343

December 20, 2011 – Introduced by Senators ERPENBACH, CARPENTER, LASSA, RISSER, TAYLOR, VINEHOUT, HOLPERIN and S. COGGS, cosponsored by Representatives RICHARDS, PASCH, BERCEAU, BERNARD SCHABER, CLARK, GRIGSBY, HEBL, HULSEY, JORGENSEN, MOLEPSKE JR, RINGHAND, SEIDEL, SINICKI, STEINBRINK, C. TAYLOR, TURNER and ZAMARRIPA. Referred to Committee on Insurance and Housing.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m) and 185.983 (1) (intro.); and ***to create*** 609.895 and 632.735 of the statutes; **relating to:** requiring certain medical loss ratios for health benefit plans.

Analysis by the Legislative Reference Bureau

Current law does not specify loss ratios that health insurers must achieve. This bill provides that, in each plan year that begins after December 31, 2010, an insurer that issues an individual or group health benefit plan must achieve a specified medical loss ratio. For individual and small group health benefit plans, that ratio is 80 percent. For large group health benefit plans, that ratio is 85 percent.

Under the bill, the medical loss ratio is the ratio of the amount of premium revenue that the insurer spends on medical costs to the total premium revenue. Medical costs are defined in the bill as costs to provide medical services, supplies, and equipment and prescription drugs to insureds, as well as the cost of activities to improve health care quality. Health benefit plans are defined in the bill as any hospital or medical policy or certificate, but various types of limited coverage, such as limited–scope dental or vision plans, separate hospital indemnity policies, and automobile medical payment insurance, are excluded. Small group health benefit plans are those provided by or through an employer with 100 employees or fewer, and large group health benefit plans are those provided by or through an employer with at least 101 employees.

The medical loss ratio requirements apply to all individual and group health benefit plans issued in this state, including defined network plans, health care plans

operated by cooperative associations, and health benefit plans offered by the state to its employees and to municipal employees.

For further information see the ***state and local*** 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. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.735, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.735, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 3. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.735, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2), (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 4. 609.895 of the statutes is created to read:

609.895 Required medical loss ratios. Defined network plans are subject to s. 632.735.

SECTION 5. 632.735 of the statutes is created to read:

632.735 Required medical loss ratios. (1) In this section:

(a) "Group health benefit plan" has the meaning given s. 632.745 (9).

(b) "Health benefit plan" has the meaning given in s. 632.745 (11).

(c) "Individual market" has the meaning given in section 2791 (e) (1) (A) of the Public Health Service Act (42 USC 300gg–91 (e) (1) (A)).

(d) "Large group market" has the meaning given in s. 632.745 (17). For purposes of this paragraph, "large employer" as used in s. 632.745 (17) has the meaning given in s. 632.745 (16), except that "101 employees" is substituted for "51 employees" wherever "51 employees" appears in s. 632.745 (16).

(e) "Medical costs" means all of the following:

1. The cost of providing medical services, medical supplies, medical equipment, and prescription drugs to insureds or enrollees.

2. The cost of activities for improving health care quality.

(f) "Small group market" has the meaning given in s. 632.745 (26). For purposes of this paragraph, "small employer" as used in s. 632.745 (26) has the meaning given in s. 635.02 (7) (a), except that "100 employees" is substituted for "50 employees" wherever "50 employees" occurs in s. 635.02 (7) (a).

(2) The medical loss ratio requirements in sub. (3) apply to every insurer that issues an individual or group health benefit plan in this state.

(3) In each plan year that begins after December 31, 2010, the ratio of the amount of premium revenue expended by an insurer on medical costs to the total

amount of premium revenue may not be less than the following applicable percentage:

(a) For each health benefit plan issued by the insurer in the individual market, 80 percent.

(b) For each health benefit plan issued by the insurer in the small group market, 80 percent.

(c) For each health benefit plan issued by the insurer in the large group market, 85 percent.

(END)