WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
- **

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INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

- *Clearinghouse Rules ... CRule*
- **

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_sb0451_SC-AI_pt04**

- *Miscellaneous ... Misc*
- **

HIRSP Health Care Reform Package

Background:

The Health Insurance Risk Sharing Plan (HIRSP) offers health insurance coverage to individuals with adverse medical histories and others who cannot obtain affordable health care coverage from the private sector.

However, this program is seeing cost increases that can not be sustained under the current system.

Since 2000, HIRSP expenses have increased more than 300% to $207 million.

The average monthly premium paid by individual HIRSP policyholders doubled to $480.

Increased costs of the program have shifted $38.9 million in costs onto the backs of privately insured individuals and families, an increase of 544% in 5 years.

The HIRSP Health Care Reform Package Talking Points:

The bill would implement a number of reforms aimed at controlling the cost of HIRSP, and was developed with the help and input of the Governor's Administration.

Controlling HIRSP costs will make the program more affordable to policyholders in the program, and reduce the cost shift onto the backs of families who purchase private health insurance.

The new board is comprised of insurers, providers and policyholders to ensure that the interests of all parties are represented as the board moves ahead with reforms.

The bill would provide needed flexibility to the newly created quasi-governmental HIRSP Authority to develop innovative plans that provide health coverage consistent with plans offered in the private sector.

The new structure of the HIRSP program will encourage the use of modern disease management techniques, provide health coverage that is consistent with the private market, and update benefits that have been changed little since 1981.

The new Authority will have the flexibility to respond to different market conditions, implement disease management program for AIDS and other chronically ill policyholders, and control the cost of prescription drugs through the use of new prescription management techniques, such as a tiered system similar to the Navitus program.

Wisconsin has **zero** GPR in the current HIRSP program, and will continue to have **zero** GPR in the newly created authority.

Many policy holders will be eligible to deduct 100% of their premium costs from their income taxes due to changes approved in the 2005-07 budget bill.

The bill will also offer a tax credit to those insurers who pay into the program, further reducing the health care cost shift on the backs of privately insured families.

This health care reform plan is aimed at controlling the costs of health care for those in the program, and those who have private insurance.

— 414- 485-1050 —

Health Insurance Risk-Sharing Plan (HIRSP) Health Care Reform at a Glance:

Key Modifications of the Bill:

1. Transform the organizational structure of HIRSP into a quasi-governmental "authority" with a board of directors empowered to make cost-saving benefit, administrative and other market-focused program changes.

- The budget proposal created a private, non-profit entity to govern HIRSP.

2. Create statutorily imposed government oversight mechanisms such as open records, open meetings, a competitive bid process for administrative contracts and a State Audit Bureau audit.

- The private non-profit entity created in the budget was not subject to standard government accountability measures.

3. Provide that the Governor appoints the 13 member HIRSP Board and its chairperson and the Senate confirms the Board and require that at least two f the five public members be HIRSP policyholders. The Commissioner of insurance would serve as a non-voting member.

- The budget proposal allowed the Commissioner of Insurance to appoint the 13 HIRSP Board members and the Senate to confirm them.

4. List the basic covered services in the state statutes consistent with federal Health Insurance Portability and Accountability Act (HIPAA) requirements for "eligible individuals" and Wisconsin mandated benefits but allow the new, more independent HIRSP Board to establish benefit levels, deductibles, co-payments and coinsurance requirements, exclusions, and limitations that are generally reflective and commensurate with comprehensive health insurance coverage offered in the private individual market in the state.

- The budget proposal delegated all benefit and plan design decisions to the private, non-profit board.

5. Require insurers and providers to contribute equally toward the cost of the premium and deductible subsidy program for individuals with incomes below $25,000, after any federal funds for high risk pools are first used to reduce the cost of the subsidy program.

- The budget proposal required all HIRSP costs including the subsidy program to be funded 60% by policyholders, 20% by insurers and 20% by provider payment rate adjustments.

6. Create additional conditions under which the Commissioner of Insurance could reject a form filing for HIRSP to include that "the level of cost-sharing is not actuarially equivalent to comprehensive individual health insurance policies offered in the private sector market in this state and would create financial hardship for eligible populations".

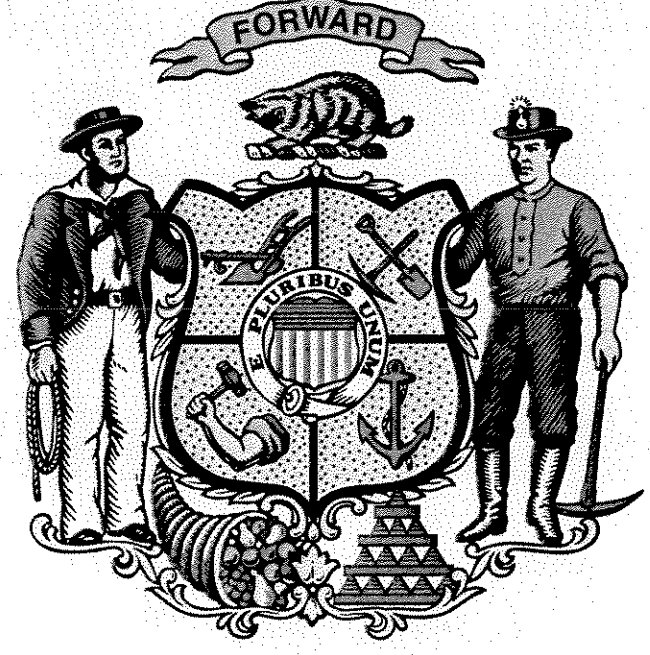
- The budget proposal allowed the Commissioner to reject a form filing if the benefit design is not comparable to a typical individual health insurance policy offered in the private sector market in this state.

7. Create a $5 million HIRSP tax credit for insurers who pay HIRSP assessments and taxes beginning in tax year 2006 and first claimable in fiscal year 2008. Allow for a 15-year carry-forward.

- The budget included a $2 million tax credit in 2006 and a $5 million tax credit in 2007 and thereafter.

8. Require the new authority to seek to create a federally qualified separate pool for the Federal Health Coverage Tax Credit (HCTC) population with no subsidization from insurers or providers. The new pool would allow the HCTC population to be eligible for a 65 percent federal refundable tax credit.

- The budget proposal did not include a pool for the HCTC population.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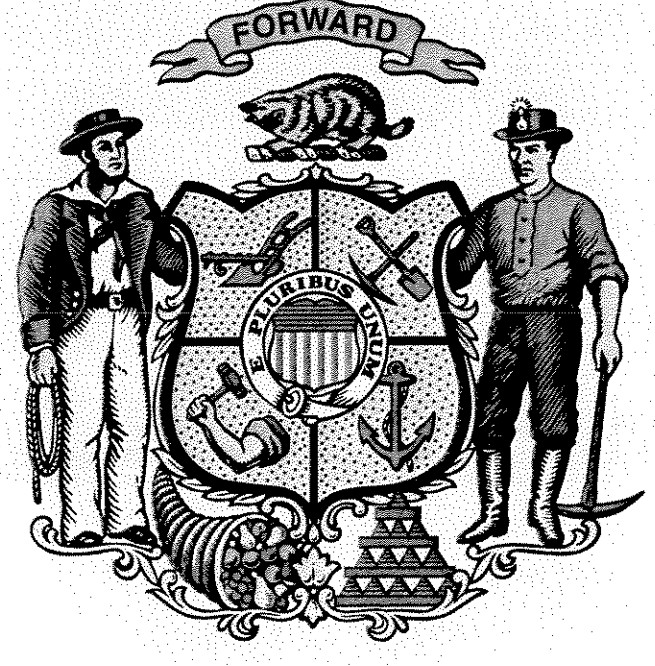
- Public Consumer ~~Advocate~~ Advocate
- Property tax exemption ~~+~~ HFRSP authority
- Medicare part D - changes

timing - transition date
issues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COMMITTEE TARGETS FOR HIRSP REFORM

- Assembly Insurance Committee
- Senate Insurance Committee
- Joint Finance Committee

ASSEMBLY AND SENATE CO-SPONSOR TARGETS FOR HIRSP REFORM

Assembly Republicans

Ann Nischke
Curt Gielow
Gregg Underheim
Phil Montgomery
Steve Wieckert
Terri McCormick
Karl Van Roy
Joan Ballweg
Terry Moulton
Kitty Rhoades
Dean Kaufert
Scott Jensen
Dave Ward
Jeff Stone
Dan Meyer
Kitty Rhodes / Moore

Senate Republicans

Dan Kapanke
Alberta Darling Y
Carol Roessler Y
Ron Brown
Neal Kedzie
Luther Olsen Y
Mary Lazich X
Scott Fitzgerald Y
Rob Cowles
Joe Leibham

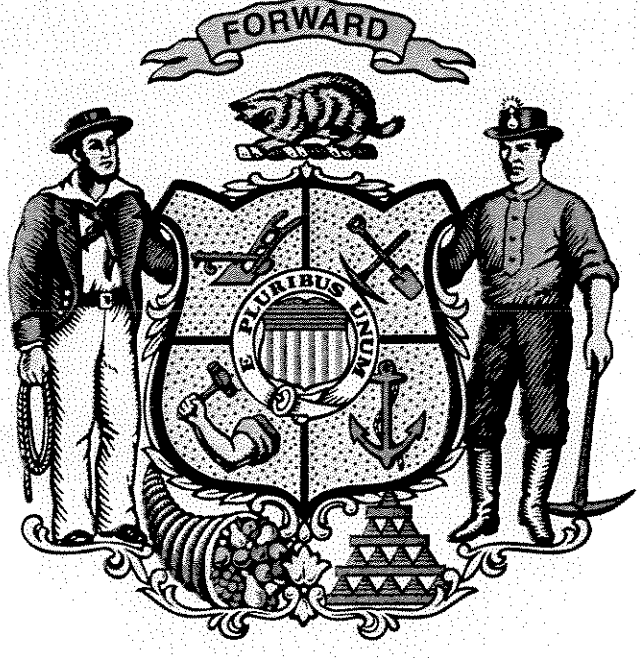
Assembly Democrats

Mark Pocan
Pedro Colon
Terese Berceau
Mike Sheridan
Tony Staskunas
Tom Nelson
Jennifer Shilling
Dave Cullen
John Lehman

Senate Democrats

Russ Decker
Lena Taylor Y
Judy Robson
Jon Erpenbach
Dave Hansen
Mark Miller
Bob Jauch

397-7391
Mike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Health Insurance Risk-Sharing Plan (HIRSP) Reform Update

Summary:

Over the last several months individual discussions have taken place with the Doyle Administration, HIRSP advocates and key legislators to develop a bipartisan HIRSP reform proposal that eases the financial burden of HIRSP on all HIRSP stakeholders and makes HIRSP more comparable to health insurance products in today's individual insurance market. The HIRSP reform proposal, that was passed by the Legislature in the State Budget but vetoed by the Governor, is being modified to respond to concerns of Doyle administration officials and HIRSP program advocates while retaining the majority of core principles in the Legislature's HIRSP proposal.

Key Modifications:

1. **Transform the organizational structure of HIRSP to a quasi-governmental "authority"** with a board of directors empowered to make cost-saving benefit, administrative and other market-focused program changes. The budget proposal created a private, non-profit entity to govern HIRSP.
2. **Create statutorily imposed government oversight mechanisms** such as open records, open meetings, a competitive bid process for administrative contracts and a State Audit Bureau audit. The private non-profit entity created in the budget was not subject to standard government accountability measures.
3. **Provide that the Governor appoints the 13 member HIRSP Board and its chairperson and the Senate confirms the Board** and require that at least two of the five public members be HIRSP policyholders. The Commissioner of Insurance would serve as a non-voting member. The budget proposal allowed the Commissioner of Insurance to appoint the 13 HIRSP Board members and the Senate to confirm them.
4. **List the basic covered services in the state statutes consistent with federal Health Insurance Portability and Accountability Act (HIPAA) requirements for "eligible individuals" and Wisconsin mandated benefits** but allow the new, more independent HIRSP Board to establish benefit levels, deductibles, copayments and coinsurance requirements, exclusions, and limitations that are generally reflective and commensurate with comprehensive health insurance coverage offered in the private individual market in the state. The budget proposal delegated all benefit and plan design decisions to the private, non-profit board.
5. **Require insurers and providers to contribute equally toward the cost of the premium and deductible subsidy program** for individuals with incomes below $25,000, after any federal funds for high risk pools are first used to reduce the cost of the subsidy program. The budget proposal required all HIRSP costs including the subsidy program to be funded 60% by policyholders, 20% by insurers and 20% by provider payment rate adjustments.

6. **Create additional conditions under which the Commissioner of Insurance could reject a form filing for HIRSP** to include that "the level of cost-sharing is not actuarially equivalent to comprehensive individual health insurance policies offered in the private sector market in this state and would create financial hardship for eligible populations". The budget proposal allowed the Commissioner to reject a form filing if the benefit design is not comparable to a typical individual health insurance policy offered in the private sector market in this state.
7. **Create a $5 million HIRSP tax credit for insurers who pay HIRSP assessments and taxes beginning in tax year 2006 and first claimable in fiscal year 2008. Allow for a 15-year carry-forward.** The budget included a $2 million tax credit in 2006 and a $5 million tax credit in 2007 and thereafter.
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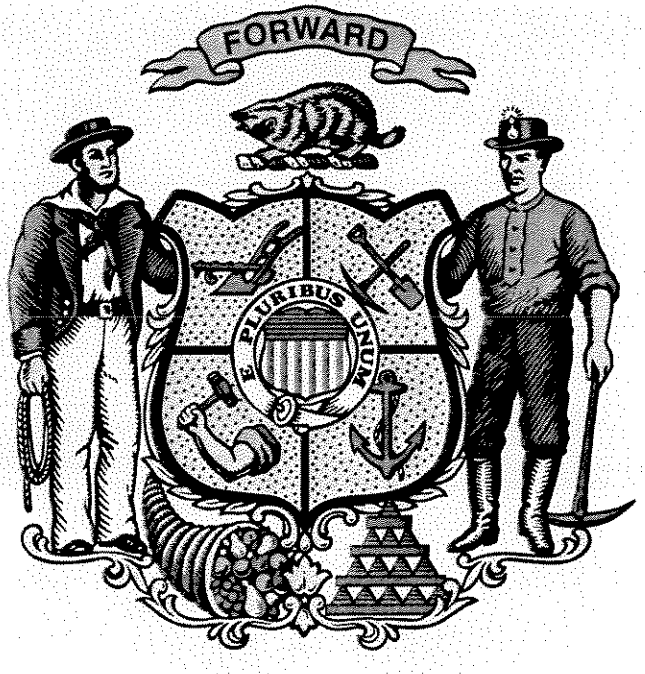
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Health Insurance Risk-Sharing Plan (HIRSP) Reform Update

DRAFT

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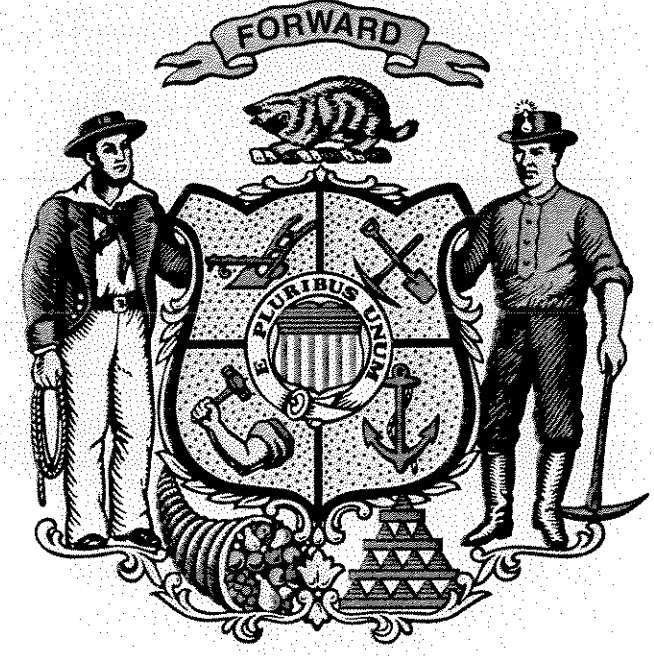
Lost jobs to foreign trade

Proposal Status:

The Legislative Drafting Bureau is in the process of drafting the proposal. The bill will be authored by key Republican legislators with support from Democrats. The Assembly and Senate Insurance Committees will hold a joint public hearing in late November, followed by separate executive committee action. The bill is targeted for floor debate in both houses in December. Some provisions of the bill will take effect on January 1, 2006, but the change to an authority will be effective July 1, 2006, to allow for a smooth transition from the Department of Health and Family Services.

Companions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Representative Rhoades
Representative Kaufert
Senator Darling
Senator Lazich

HEALTH AND FAMILY SERVICES -- HIRSP AND PUBLIC HEALTH

Convert the Health Insurance Risk-Sharing Plan (HIRSP) to a Private Nonprofit Organization

Motion:

Move to incorporate the provisions of LRB0243, relating to the administration of the health insurance risk-sharing plan (HIRSP), into the bill.

Reduce funding for HIRSP benefits and administration by $45,942,900 SEG in 2005-06 and by $145,797,000 SEG in 2006-07 and delete 4.83 SEG positions, beginning January 1, 2006.

Delete all of the Governor's statutory changes in AB 100 relating to HIRSP (pp. 263 thru 266, Items #2 thru #6 of the LFB Summary of AB 100).

Note:

In general, the motion would transfer responsibility for administering the health insurance risk-sharing plan (HIRSP) to a private, nonprofit association governed by a board of directors empowered to make benefit, eligibility, cost containment, administrative and other changes to the program.

Current Law -- HIRSP Structure and Administration

Under current law, HIRSP offers health insurance coverage to individuals with adverse medical histories and others who cannot obtain affordable health care coverage from the private sector. The Department of Health and Family Services (DHFS) and a 13-member Board of Governors administer HIRSP. The HIRSP Board of Governors consists of the DHFS Secretary (or a designee from DHFS), who serves as chair, the Commissioner of Insurance (or a designee from OCI), and the following 11 members appointed by the Secretary of DHFS to staggered, three-year terms: two participating insurers representing nonprofit organizations, two other participating insurers, three health care providers, and four public members. Of the four public members, at least one must have coverage under HIRSP, and one must be a representative of a small business in the state. Further, none of the public members may be professionally affiliated with the practice of medicine, a hospital, or an insurer. Finally, the three health care provider representatives must include one representative of the Wisconsin Medical Society, one representative of the Wisconsin Hospital Association, and one representative of an integrated multi-disciplinary health system.

Current law establishes a separate, nonlapsible HIRSP fund managed by the State of Wisconsin Investment Board and consisting of revenue from insurer assessments and enrollee premiums. Benefits and administrative expenses from the fund are paid from state appropriations to DHFS.

Motion -- HIRSP Structure and Administration

The draft would transform HIRSP into a legally distinct, nonprofit organization governed by a board of directors empowered to make benefit, eligibility, cost containment, administrative, and other changes to the program. Direct that, no later than September 1, 2005, the Commissioner of Insurance shall nominate 13 individuals to serve as the initial directors of the board of the new organization including: four representatives of participating insurers; four health care provider representatives, including one representative of the Wisconsin Medical Society, one representative of the Wisconsin Hospital Association, one representative of the Pharmacy Society of Wisconsin, and one representative of a health care provider that provides services to persons with coverage under the plan; and, among the remaining five members, at least one who represents small businesses that provide health insurance, and at least one who has coverage under the plan. Board members are to be confirmed by the Senate.

Direct that the board form a private, nonprofit organization under Chapter 181 of the statutes and take all actions necessary to exempt the organization from federal taxation. The draft also specifies that the organization is exempt from state income taxation. The board assumes HIRSP administrative duties exercised under current law by DHFS, the HIRSP board, or the HIRSP plan administrator. OCI will assess insurers and forward assessment revenue to the board. Policyholder premiums and insurer assessments will be paid into a fund, which will be outside the state treasury. The board will control the assets of the fund and will select regulated financial institutions in which to establish accounts. The board will pay the operating expenses of the HIRSP plan from the fund. As a condition for the release of the assessment revenue from OCI, the organization, through the board, agrees to administer the plan in conformance with Chapter 149 of the statutes.

The transfer of HIRSP administration to the new board takes effect on January 1, 2006.

Current Law -- DHFS Oversight

The DHFS Secretary, in addition to chairing the HIRSP Board of Governors, has a number of responsibilities relating to the operation of the plan. The statutes require the DHFS Secretary to promulgate a variety of administrative rules governing the operation of HIRSP, including rules to: (a) operate the plan; (b) establish annual HIRSP premium rates, insurers' assessments, and provider payment rates; (3) adjust premiums, insurers' assessments, and provider payment rates as necessary to meet the costs of the plan; and (4) permit certain persons who receive government reimbursements or copayments to continue to be eligible for the plan. DHFS may also promulgate rules relating to premium rates, insurer assessments, and provider payment adjustments as emergency rules. DHFS may establish the following limits on covered services by promulgating administrative rules to: (a) apply the same utilization and cost control

procedures that apply under rules established for MA, except that DHFS cannot apply the same copayments to HIRSP plan participants as apply to MA recipients; (b) limit the amount of services provided to individuals with chronic mental illness in community support programs; and (c) establish copayments, coinsurance, and out-of pocket limits for prescription drugs, subject to the approval of the Board of Governors. Further, DHFS may limit coverage of prescription drugs to only those claims submitted by pharmacists directly to the plan administrator. Finally, DHFS, in consultation with the Board, is required to establish a program budget for each plan year. DHFS may not implement the budget unless approved by the Board.

Motion -- DHFS Oversight

Under the draft, DHFS has no role in the HIRSP program. Generally, under the draft, the board assumes any responsibilities DHFS has under current law.

Current Law -- OCI Oversight

Under current law, the OCI Commissioner or his or her designee serves on the HIRSP Board. Additionally, OCI is required to assess each insurer its proportional share of the HIRSP costs to be paid by insurers, as determined by DHFS. OCI is required to calculate each insurer's portion and to notify DHFS of the insurers that are to share in the costs. OCI may, by rule, exempt as a class, those insurers whose share would be so minimal as to not exceed the estimated cost of levying the assessment. OCI may, by rule, require insurers to submit information that is necessary for OCI, DHFS, and the Board of Governors to carry out their responsibilities related to the administration of HIRSP.

Motion -- OCI Oversight

Under the draft, the OCI Commissioner nominates the board of directors for the new organization to administer HIRSP, but does not serve on the board of directors. The OCI Commissioner's duties to assess insurers and enforce assessments continue, and the draft creates an appropriation in the Chapter 20 schedule under OCI to which the assessments are deposited, and from which the assessment revenue is paid to the new nonprofit organization.

Additionally, policies designed by the board of the new nonprofit organization are subject to OCI approval. OCI may disapprove any policy designed by the board that has a benefit design that is not comparable to a typical individual health insurance policy offered in the private sector market in the state.

Current Law -- HIRSP Eligibility

Under current law, Wisconsin residents are eligible to enroll in HIRSP as a result of having health insurance coverage rejected or limited by an insurer, as a result of having certain diseases or disabilities, or as a result of the loss of employer-sponsored health care coverage. Current law defines "resident," in part, as a person who has been legally domiciled in this state for at least 30 days.

Individuals under the age of 65 may apply for enrollment in HIRSP if, during the nine months prior to the application, they received and submitted with their application, any of the following, based wholly or partially on medical underwriting considerations: (a) notice of rejection or cancellation of coverage from one or more health insurers; (b) notice of reduction or limitation in coverage, including restrictive riders, from an insurer if the effect of the reduction 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) notice of an increase in premium of 50 percent or more for a current policy, unless the increase is applicable to all of the insurer's health insurance policies then in effect; (d) notice of a premium for a prospective policy from two or more insurers that is 50 percent or more in excess of the premium that would be paid by persons considered a standard risk for similar coverage.

Individuals under the age of 65 may also be eligible for coverage under HIRSP without having received any of the notices described above if they have certain diseases or disabilities. Persons may enroll in HIRSP if they submit evidence of a positive test for the human immunodeficiency virus (HIV) or an antibody to HIV; (b) coverage under Medicare because of a disability -- defined as a condition which causes the individual to be unable to perform substantial, gainful activity because of a physical or mental impairment which will last at least 12 months.

Additionally, persons may also be eligible for HIRSP under current law if they meet all of the following requirements: (a) the aggregate of the individual's period of creditable health care insurance 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 or part B of Medicare or medical assistance (MA) 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) the individual elected to continue coverage if the individual was offered the option of continuation coverage under a federal continuation provision; and (f) the individual has exhausted the federal continuation coverage. Eligibility under these conditions is structured to meet the "acceptable alternative mechanism" requirements of the federal Health Insurance Portability and Accountability Act (HIPAA).

Motion -- HIRSP Eligibility

The draft continues eligibility for all persons currently eligible for HIRSP. However, under the draft, to be eligible to enroll in HIRSP as a result of having health insurance coverage rejected, an individual must submit notices of rejection from two or more insurers (as opposed to one or more under current law). Also, the draft continues the "acceptable alternative mechanism" eligibility conditions that meet HIPAA requirements. The draft allows the HIRSP board of directors to establish criteria that would enable additional persons to be eligible for coverage under the plan, as long as the board ensures that the 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. Finally, the draft

defines "resident," in part, as a person who has been legally domiciled in this state for a period of at least six months.

Current Law -- Plans, Coverage, Premiums, and Subsidies

Under current law, HIRSP offers two types of plans, both of which provide coverage for major medical expenses. Plan 1 is for individuals who meet specified eligibility criteria but are not eligible for Medicare. Plan 1 offers two deductible options: Plan 1A has a $1,000 deductible for enrollees with annual household income of $20,000 or more; Plan 1B has a $2,500 deductible for all enrollees. Plan 2 is for individuals who meet the specified eligibility criteria and who are eligible for Medicare. The effective deductible for Plan 2 enrollees is $500. Coverage for Plan 2 is limited to those benefits not paid by Medicare Part A or B, regardless of whether the individual is enrolled in Part B. Current law specifies expenses that must be covered and expenses that must be excluded under HIRSP. HIRSP standard plan features contain a number of cost sharing and benefit limitation provisions referenced in statute, including medical deductibles, medical and prescription drug coinsurance, limits on out-of-pocket costs, waiting periods for preexisting conditions, and a lifetime benefit maximum of $1 million.

Current law requires that 60 percent of the projected operating and administrative costs of the program be funded by premium revenues, and that 20 percent of HIRSP costs be paid from insurer assessments. Reduced reimbursements to providers account for the remaining 20 percent of HIRSP costs. Premium rates for Plan 1 must be set at a level no lower than 140 percent, nor higher than 200 percent, of the rate that would be charged under an individual policy providing substantially the same coverage and deductibles as HIRSP. Current law also prescribes the criteria for setting Plan 2 rates.

Current law provides that individuals with less than $25,000 in annual household income are eligible for a subsidy to cover a portion of their premium if enrolled in Plan 1A or Plan 2. Plan 1B enrollees are not eligible for a premium subsidy. Individuals with annual income less than $20,000 are eligible for a subsidy to cover a portion of their deductible if enrolled in Plan 1A. Enrollees in Plans 1B and 2 are not eligible for deductible subsidies. Premium and deductible subsidies are funded equally from assessments on health insurers and reduced provider payments.

Motion -- Coverage, Premiums, and Subsidies

The draft provides that the board shall determine the design of the plan, including the covered expenses, expenses excluded from coverage, deductibles, copayments, coinsurance, out-of-pocket limits, and coverage limitations. Policies designed by the board are subject to OCI approval, and OCI may disapprove any policy designed by the board that has a benefit design that is not comparable to a typical individual health insurance policy offered in the private sector market in the state. The draft repeals statutory sections related to coverage exclusions, prescription drug coverage, deductibles, copayments, coinsurance, and out-of-pocket limits, premium rates, and preexisting conditions. The draft directs the board to establish provider payment rates for covered expenses, including pharmacy expenses, that consist of the allowable charges paid under MA for the services plus an enhancement determined by the board. Additionally, the draft repeals a

provision directing that DHFS, by rule, apply to HIRSP the same utilization and cost control procedures that apply under MA rules promulgated by DHFS. For HIRSP enrollees eligible for Medicare, coverage will be limited to those benefits not paid by Medicare Part A, B, or D. Medicare Part D, which goes into effect on January 1, 2006, is the drug benefit added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The draft also directs the board to seek to qualify HIRSP under federal regulations as a state pharmacy assistance program (SPAP) -- which is a program that provides senior citizens and individuals with disabilities increased access to prescription drugs. If HIRSP is designated as a SPAP, drug costs paid by HIRSP for Plan 2 enrollees will count toward the enrollees' coinsurance requirement in the Part D benefit "coverage gap" -- that is, the difference between the initial Part D coverage limit and the catastrophic threshold. The draft retains the $1 million lifetime benefit maximum.

The draft retains the requirements that plan costs be paid 60 percent from enrollee premiums, but repeals the requirements that premiums be set no lower than 140 percent, nor higher than 200 percent, of the amount that would be charged under an individual policy providing substantially the same coverage. The draft also repeals the criteria for setting Plan 2 rates. The draft retains the current law requirements that 20 percent of plan costs be paid through insurer assessments, and 20 percent from adjustments to provider payment rates. Additionally, the draft specifies that the board shall provide for subsidies for premiums, deductibles, and copayments for eligible persons with household incomes below a level established by the board. However, the draft provides that any premium and deductible subsidy costs will be split among policy holders, insurers, and providers according to the same 60 percent/20 percent/20 percent allocation of other HIRSP plan costs.

Current Law -- Plan Administration

Current law provides that a HIRSP plan administrator may be selected by DHFS in a competitive bidding process. The HIRSP plan administrator is to: (1) perform all eligibility and administrative claims payment functions relating to the plan; (2) establish premium billing procedures for collection of premiums from insured persons; (3) perform all necessary functions to assure timely payment of benefits to persons covered under the plan, including making information available relating to the proper manner of submitting a claim and distribution of claim submission forms, evaluating the eligibility of each claim for payment under the plan, and notifying each claimant within 30 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected, or compromised; (4) under the direction of DHFS, pay claims expenses from the premium payments received from or on behalf of persons covered under the plan. If the plan administrator's payments for claims expenses exceed premium payments, the Board of Governors must forward to DHFS, and DHFS must provide to the plan administrator, additional funds for payment of claims expenses. The plan administrator is paid for its direct and indirect costs from the HIRSP fund. Allowable expenses include that portion of the administrator's costs for printing, claims administration, customer service, financial and operational reporting, building overhead costs, and other actual operating and administrative expenses. In addition to contracting with the plan administrator for administrative services, DHFS contracts with the Legislative Audit Bureau to conduct annual financial audits of HIRSP.

DHFS has contracted with a new plan administrator that began its duties in April, 2005.

Motion -- Plan Administration

The draft repeals the plan administrator provision and directs that the board adopt policies to administer the HIRSP statute, including the authority to delegate any part of its powers or procedures. This includes the authority to contract for plan administration. The draft would require that DHFS terminate the existing plan administrator contract and that the nonprofit organization assuming the responsibility for administering HIRSP contract with the same plan administrator under the same terms and conditions.

The board is to annually report to the Legislature and the Governor on the operation of the plan. The board is to: (a) perform all eligibility and administrative claims payment functions; (b) establish a premium billing procedure for collecting premiums from insured persons; and (c) perform all necessary functions to assure timely payment of benefits to covered persons under the plan.

Current Law -- Case Management Pilot Program

2001 Wisconsin Act 16 directed DHFS to establish a community-based case management services demonstration pilot. The pilot program would last three years and may include up to 300 enrollees. Participation in the program is voluntary and each enrollee must satisfy any of the following criteria: (a) the enrollee was diagnosed with a chronic disease; (b) the enrollee takes two or more prescribed medications on a regular basis; and (c) the enrollee was treated at least twice in a hospital emergency room, or admitted at least twice to a hospital as an inpatient, within six months of applying for the pilot. A team would provide the community-based case management services. The team consists of a nurse case manager, a pharmacist, a social worker, and the primary care physician. Case management services provided would include initial intake assessment, development of a treatment plan, coordination of health care services, patient education, family support, and monitoring and reporting of patient outcomes and costs.

DHFS issued a request for proposals for the case management pilot program and received proposals from two service providers. According to DHFS, at the time the HIRSP Board was evaluating the proposals, it was also considering a much more comprehensive disease management program and began working to include disease management in its next plan administrator contract. DHFS has included case management services in its new plan administrator contract and requested in its 2005-07 biennial budget request that it no longer be required to establish a separate case management pilot program.

Motion -- Case Management

The draft deletes the statutory provisions relating to the case management pilot program upon passage of the bill.

Current Law -- HIRSP Staffing

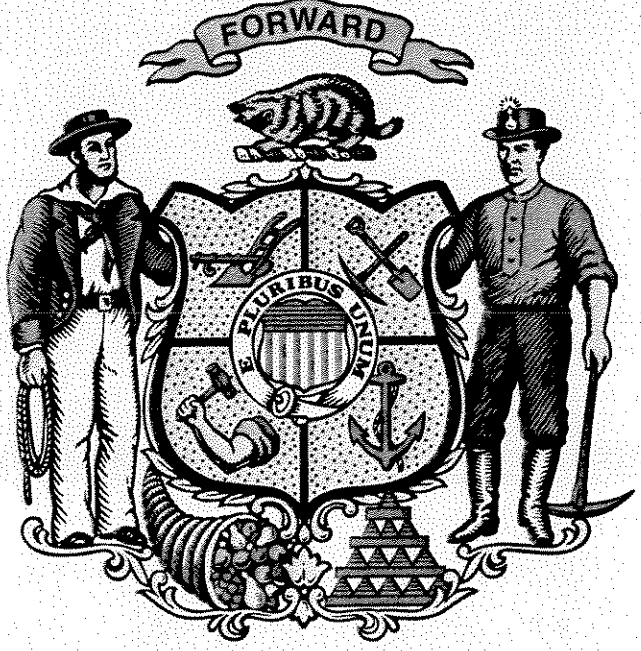
Under current law, 4.83 DHFS SEG positions are paid from the appropriation for HIRSP administrative services. These positions include 1.0 health care rate analyst position, 1.0 contracts specialist position, 1.0 program and planning analyst position, 1.0 health care financing

supervisor position, 0.50 program assistant position, and small fractions of health care financing manager, budget and policy analyst, and program assistant positions.

Motion -- HIRSP Staffing

The draft eliminates the DHFS appropriation for HIRSP administrative services and deletes the 4.83 SEG positions paid from the appropriation effective January, 1, 2006. The private, nonprofit organization to be formed pursuant to the draft would have the authority to hire staff to administer the HIRSP program.

[Change to Bill: -$191,739,900 SEG]


FORWARD
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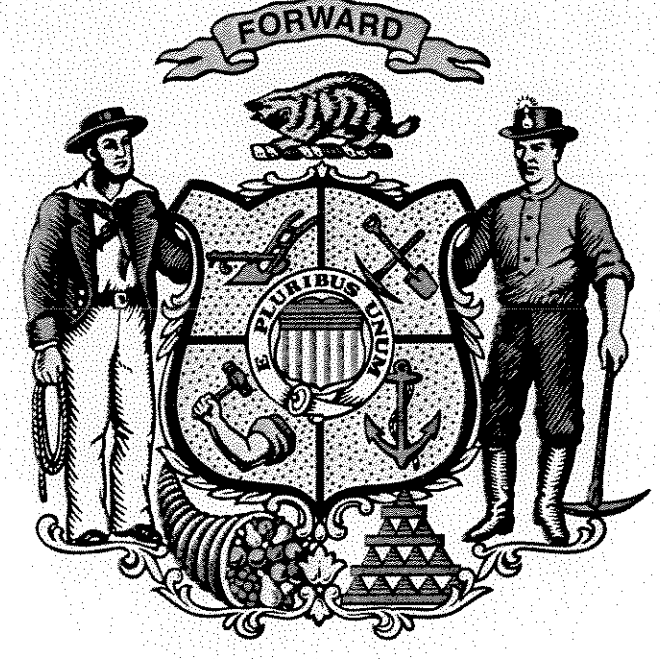
Assembly	Senate
Nischke	Kapanke
Gielow	Taylor
Jensen	Olsen
Kreuser	Brown
Seidel	Schultz
Montgomery	Darling
McCormick	Fitzgerald
Moulton	Roessler
Townsend	
Gard	
Huebsch	
Honadel	
Shilling	
Hundertmark	
Sinicki	
Ballweg	
Lehman	
Fitzgerald	
Hahn	
Molepske	
Gottlieb	
Sheridan	
Underheim	
Boyle	
Vruwink	
Nelson	
Krawczyk	
Van Roy	
Stone	
Rhoades	


FORWARD
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The new provisions could result in tax decreases for some firms and tax increases for others. The net fiscal impact is unknown.

Joint Finance/Legislature: Adopt the treatment of gross receipts from the use of computer software and services. Delete all other provisions, including authority for DOR to promulgate administrative rules that specify how income should be apportioned if the income from sales, other than sales of tangible personal property, cannot be ascertained with reasonable certainty. It is likely that there would be a significant decrease in income and franchise tax liabilities as a result of these provisions. However, data is not available to accurately estimate the fiscal effect.

[Act 25 Sections: 1261, 1262, 1272 thru 1281, 1298, 1305, 1312, 1319, 1320 thru 1322, 1341 thru 1349, 1376, 1383 thru 1385, 1405, 1406, 1419, 1426 thru 1428, 1429, 1430, and 9341(14v)]

20. INDIVIDUAL AND CORPORATE INCOME AND FRANCHISE AND INSURANCE PREMIUMS TAX CREDIT FOR HIRSP ASSESSMENTS

	Jt. Finance/Leg. (Chg. to Base)	Veto (Chg. to Leg)	Net Change
GPR-REV	- $2,000,000	$2,000,000	$0

Joint Finance/Legislature: Create a nonrefundable credit under the insurance premiums tax, the corporate and individual income and franchise taxes, and the tax on investment income paid by life insurance companies equal to a percentage of the amount of assessments paid by the insurer during the taxable year under the health insurance risk sharing plan (HIRSP). Require DOR, in consultation with the Office of the Commissioner of Insurance, to determine the credit percentage for each year so that the annual cost of the credit is as close as practicable to $2 million in the 2006-07 fiscal year, and $5 million in each fiscal year thereafter. Provide that unused credits could be carried forward fifteen years to offset future tax liabilities. Specify that the credit would first apply to tax years beginning on January 1, 2006.

Veto by Governor [F-6]: Delete provision.

[Act 25 Vetoed Sections: 1311i, 1312r, 1319m, 1354m, 1385h, 1385p, 1386m, 1406m, 1428k, 1428p, 1474q, 1474s, and 1686f]

7. HIRSP -- CONVERSION TO A PRIVATE NONPROFIT ORGANIZATION

	Funding	Positions
SEG	- $305,800,100	- 4.83

Joint Finance: Reduce funding for HIRSP benefits and operations by $113,307,400 in 2005-06 and $192,492,700 in 2006-07 and delete 4.83 positions, beginning on January 1, 2006. Transfer responsibility for administering HIRSP to a private, nonprofit association governed by a board of directors empowered to make benefit, eligibility, cost containment, administrative and other changes to the program. The transfer of HIRSP administration to the new board would take effect on January 1, 2006.

Eliminate the separate, nonlapsible HIRSP fund managed by the State of Wisconsin Investment Board. Transfer the unencumbered assets of the fund to the HIRSP plan administered by the nonprofit association effective January 1, 2006. Transfer the unencumbered balances in the appropriation accounts for HIRSP administration and benefits to the HIRSP plan administered by the nonprofit association effective January 1, 2006.

Transform HIRSP into a legally distinct, nonprofit organization governed by a board of directors empowered to make benefit, eligibility, cost containment, administrative, and other changes to the program. Require that, no later than September 1, 2005, the Commissioner of Insurance nominate 13 individuals to serve as the initial directors of the board of the new organization including: four representatives of participating insurers; four health care provider representatives, including one representative of the Wisconsin Medical Society, one representative of the Wisconsin Hospital Association, one representative of the Pharmacy Society of Wisconsin, and one representative of a health care provider that provides services to persons with coverage under the plan; and, among the remaining five members, at least one who represents small businesses that provide health insurance, and at least one who has coverage under the plan. Board members are to be confirmed by the Senate.

Direct that the board form a private, nonprofit organization under Chapter 181 of the statutes and take all actions necessary to exempt the organization from federal taxation. Specify that the organization is exempt from state income taxation. The board would assume HIRSP administrative duties exercised under current law by DHFS, the HIRSP board, or the HIRSP plan administrator.

Direct the Commissioner of Insurance to assess insurers and enforce assessments. Create an appropriation in OCI to which the assessments would be deposited and from which the assessment revenue would be paid to the new nonprofit organization. Policyholder premiums and insurer assessments would be paid into a fund, which would be outside the state treasury. The board would control the assets of the fund and select regulated financial institutions in which to establish accounts. The board would pay the operating expenses of the HIRSP plan from the fund. As a condition for the release of the assessment revenue from OCI, the organization, through the board, would agree to administer the plan in conformance with Chapter 149 of the statutes. Provide that no cause of action may arise against and no liability may be imposed upon the organization, plan, or board; or any agent, employee, or director of any of them; or contributor 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 Chapter 149 of the statutes.

Continue eligibility for all persons currently eligible for HIRSP. Provide that, to be eligible to enroll in HIRSP as a result of having health insurance coverage rejected, an individual must submit notices of rejection from two or more insurers. Authorize the HIRSP board of directors to establish criteria that would enable additional persons to be eligible for coverage under the plan, as long as the board ensures that the 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. Define "resident," in part, as a person who has been legally domiciled in this state for a period of at least six months. Specify that a person is not eligible for coverage under the plan if the person is eligible for the following medical assistance-related programs: (a) services under a medical assistance waiver; (b) a community integration program for residents of state centers; (c) a community integration program for persons relocated or meeting reimbursable levels of care; (d) a community integration program and brain injury waiver program for persons with developmental disabilities; (e) medical assistance as part of a family care benefit; (f) a specified pilot program for long-term care of children with disabilities; (g) a specified autism spectrum disorder waiver program; (h) services provided under the program of all-inclusive care for persons aged 55 or older authorized under 42 USC 1396u-4; (i) services provided under the demonstration program under a federal waiver authorized under 42 USC 1315; and (j) health care coverage under BadgerCare.

Require the board to determine the design of the plan, including the covered expenses, expenses excluded from coverage, deductibles, copayments, coinsurance, out-of-pocket limits, and coverage limitations. Policies designed by the board would be subject to OCI approval, and OCI could disapprove any policy designed by the board that has a benefit design that is not comparable to a typical individual health insurance policy offered in the private sector market in the state. Repeal statutory sections related to coverage exclusions, prescription drug coverage, deductibles, copayments, coinsurance, and out-of-pocket limits, premium rates, and preexisting conditions. Direct the board to establish provider payment rates for covered expenses, including pharmacy expenses, that consist of the allowable charges paid under MA for the services plus an enhancement determined by the board. Repeal a provision directing that DHFS, by rule, apply to HIRSP the same utilization and cost control procedures that apply under MA rules promulgated by DHFS. For HIRSP enrollees eligible for Medicare, coverage would be limited to those benefits not paid by Medicare Part A, B, or D. Direct the board to seek to qualify HIRSP under federal regulations as a state pharmacy assistance program (SPAP) -- which is a program that provides senior citizens and individuals with disabilities increased access to prescription drugs. If HIRSP were designated as a SPAP, drug costs paid by HIRSP for Plan 2 enrollees would count toward the enrollees' coinsurance requirement in the Part D benefit "coverage gap" -- that is, the difference between the initial Part D coverage limit and the catastrophic threshold. Provide for a $1 million lifetime benefit maximum.

Direct that plan costs be paid 60 percent from enrollee premiums. Repeal the requirements that premiums be set no lower than 140 percent, nor higher than 200 percent, of

the amount that would be charged under an individual policy providing substantially the same coverage. Repeal the criteria for setting Plan 2 rates. Continue to provide that 20 percent of plan costs be paid through insurer assessments, and 20 percent from adjustments to provider payment rates. Require the board to provide for subsidies for premiums, deductibles, and copayments for eligible persons with household incomes below a level established by the board. Provide that any premium and deductible subsidy costs would be split among policyholders, insurers, and providers according to the same 60/20/20 percent allocation of other HIRSP plan costs.

Repeal the plan administrator provision and direct that the board adopt policies to administer the HIRSP statute, including the authority to delegate any part of its powers or procedures. This includes the authority to contract for plan administration. Direct DHFS to terminate the existing plan administrator contract and provide that the nonprofit organization assuming the responsibility for administering HIRSP contract with the same plan administrator under the same terms and conditions.

Require the board to annually report to the Legislature and the Governor on the operation of the plan. The board would: (a) perform all eligibility and administrative claims payment functions; (b) establish a premium billing procedure for collecting premiums from insured persons; and (c) perform all necessary functions to assure timely payment of benefits to covered persons under the plan.

Delete current provisions relating to the case management pilot program upon passage of the bill. [The Governor had also recommended this change. See Item #6.]

Eliminate the DHFS appropriation for HIRSP administrative services and delete the 4.83 SEG positions paid from the appropriation, effective January, 1, 2006. The private, nonprofit organization would have the authority to hire staff to administer the HIRSP program.

Senate/Legislature: Include provision. In addition, prohibit the new board of directors from establishing plan rates that exceed 200 percent of rates applicable to individual standard risks.

Veto by Governor [C-2]: Delete all of these provisions, including the new appropriation for OCI to pay the Board revenues it collects from insurer assessments ($25,171,800 PR in 2005-06 and $39,292,800 PR in 2006-07). However, the Governor is unable to restore SEG funding and positions in DHFS that had been deleted in Enrolled AB 100 as part of this proposal. The fiscal effect of the Governor's partial veto is summarized under "Insurance."

[Act 25 Section: 1154]

[Act 25 Vetoed Sections: 140 (as it relates to s. 20.145(5)), 156w, 320p, 320r, 522c, 535m, 535p, 535r, 1286c, 1354L, 1406f, 2032m thru 2065, 2429c thru 2429r, 9121(13p), 9221(3p), 9321(4L), 9321(4p), 9341(19p), and 9421(5p)]