State of Wisconsin
1995 - 1996 LEGISLATURE

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1995 ASSEMBLY BILL 500

August 7, 1995 - Introduced by Representatives WOOD, UNDERHEIM, GROBSCHMIDT, HUBER, KLUSMAN, KRUSICK, SPRINGER, F. LASEE, ALBERS, ZIEGELBAUER, GOETSCH, LADWIG, MUSSER, BALDUS, BOYLE, REYNOLDS, HASENOHRL, KREUSER, HAHN, OTTE and OLSEN, cosponsored by Senators WEEDEN, HUELSMAN and ANDREA. Referred to Committee on Health.

AN ACT ***to repeal*** 49.47 (6) (a) 1. and 49.47 (6) (a) 6m.; ***to renumber*** 632.72 (1) and 632.755 (2); ***to renumber and amend*** 49.002 (2), 49.01 (5m), 49.043, 49.06 (3), 49.47 (6) (a) (intro.), 49.47 (6) (a) 6., 49.47 (6) (a) 7. and 635.01; ***to consolidate, renumber and amend*** 49.035 (1) (intro.) and (d) and 49.046 (3) (b) 1. to 3.; ***to amend*** 20.435 (4) (eb), 40.51 (8), 40.51 (9), 40.51 (15m), 46.275 (6), 46.278 (8), 49.015 (3), 49.032 (4r), 49.035 (2) (b) 7. and 8., 49.035 (2) (cm) (intro.), 49.035 (4e) (a) and (b), 49.035 (6) (am) and (b), 49.43 (8), 49.43 (10), 49.45 (8m) (intro.), 49.45 (24m) (a), 49.45 (37) (intro.), 49.46 (2) (a) (intro.), 49.46 (2) (b) (intro.), 49.475 (1) (a), 613.03 (3), 625.12 (2), 625.15 (1), 625.22 (1), 628.34 (3), 628.36 (2) (b) 5. and 632.70; and ***to create*** 20.145 (9), 40.51 (17), 46.27 (11) (e), 49.002 (2) (b), 49.01 (5m) (b), 49.02 (5m), 49.02 (20), 49.035 (4e) (d), 49.043 (2), 49.046 (3) (b) 2., 49.046 (4) (bm), 49.06 (3) (b), 49.44, 49.45 (50), 49.46 (2) (bm), 49.465 (10), 49.47 (6) (ag) 7., 49.47 (6) (as), 49.47 (15), 49.49 (7), 632.72 (1c), 632.755 (2) (a), 635.01 (2) and chapter 637 of the statutes; **relating to:** creating a basic health insurance plan, establishing a subsidy program for premiums under that plan, seeking a federal waiver or federal legislation regarding medical assistance, medical assistance benefits and providers,

medical benefits under the general relief and relief of needy Indian persons programs, granting rule–making authority and making appropriations.

Analysis by the Legislative Reference Bureau

This bill requires the department of health and social services (DHSS) to request a waiver, developed in consultation with and approved by the commissioner of insurance (commissioner), from the secretary of the federal department of health and human services to allow the state to receive federal funding to provide health care coverage under a basic health insurance plan (basic plan), to be designed by rule and administered by the commissioner, to certain persons who are eligible for medical assistance for reasons related to aid to families with dependent children eligibility (covered persons). If the waiver request is denied, DHSS is required to seek federal legislation instead of a waiver. Any waiver or legislation must seek to obtain an amount of federal funding, expressed as a percentage of total program costs, including both administrative and benefit costs, to cover eligible persons under the basic plan that either exceeds or is substantially equivalent to the amount of federal funding, expressed as a percentage of total program costs, including both administrative and benefit costs, available to provide medical assistance to covered persons. If DHSS determines that a waiver is approved, or legislation is enacted, that meets the maintenance of federal effort requirement and if DHSS determines that state legislation has been enacted making appropriations specifically for the purpose of providing health care coverage under the basic plan to covered persons and specifically for the purpose of funding premium subsidies, DHSS is required to certify its determination to the commissioner on the first day of the first month beginning after the waiver is approved or the legislation is enacted. The commissioner is required to implement that basic plan coverage no later than the first day of the 12th month beginning after the certification is made.

The basic plan is to be designed to provide basic coverage of hospital, surgical and medical services and items. It must provide both single and family coverage; it must require a copayment of at least $2 for every service or item covered; it may be exempted by the commissioner from any health insurance mandate; and it may not provide abortion coverage except in a case of sexual assault or incest or if the abortion is medically necessary to save the life of the woman or to prevent grave, long–lasting physical health damage to the woman due to a medical condition existing prior to the abortion. Any employer, including the state and its political subdivisions, and any individual who is a resident of this state and who does not have coverage under the basic plan through an employer, except for an individual who has coverage under the health insurance risk sharing plan (HIRSP), is eligible to purchase coverage under the basic plan. Such an employer or individual who voluntarily terminates coverage under the basic plan is not eligible again for coverage under the basic plan for 12 months.

The commissioner may, but is not required to, divide the state into regions for the purpose of pooling individuals and employes with coverage under the basic plan. The commissioner must select insurers to provide coverage under the basic plan by using a competitive sealed proposal process.

An insurer that is selected by the commissioner to provide coverage must provide coverage under the basic plan, without regard to health condition or claims experience, to any employer that agrees to pay the premium and comply with all other plan provisions and to any of the employer's employes and their dependents; to any individual who is eligible for coverage and who agrees to pay the premium and comply with all other plan provisions and to such an individual's dependents; and to any individual who is entitled to coverage and to such an individual's dependents. Coverage under the basic plan must be community rated. The community rates, however, may be modified according to the insured's age, gender, geographic area and tobacco use and by whether the insured's coverage is single or family. The commissioner must by rule prescribe rate bands for the modifications and may also by rule prescribe rate restrictions that provide for a transition to the modified community rates.

The basic plan may not deny, exclude or limit benefits on account of a preexisting condition for more than 12 months after the commencement of coverage (and may not deny, exclude or limit benefits on account of a preexisting condition for any amount of time for a person who has coverage because he or she is eligible for medical assistance) and may not define a preexisting condition more restrictively than a condition for which the insured sought or should have sought medical care during the 12 months immediately preceding coverage or more restrictively than a pregnancy existing on the effective date of coverage, except that coverage may not be excluded for covered expenses for such a pregnancy that exceed $5,000. An individual who has been a resident for at least 6 months or an employe may obtain coverage without any preexisting condition exclusion or limitation if he or she applies for coverage during a biennial 30–day open enrollment period specified by the commissioner by rule. Additionally, the basic plan must waive any period applicable to a preexisting condition exclusion or limitation that was satisfied under another health care plan, including medical assistance but excluding HIRSP, under which the insured had coverage that terminated 60 days or fewer before the effective date of coverage under the basic plan. These preexisting condition exclusion or limitation and portability provisions are very similar to those required under current law for a group health benefit plan issued to a small employer (one that employs between 2 and 25 employes with a normal work week of 30 or more hours). Under current law, a group health benefit plan issued to a small employer may not exclude or limit benefits on account of a preexisting condition for more than 12 months after the commencement of coverage and may not define a preexisting condition more restrictively than a pregnancy existing on the effective date of coverage or a condition for which the insured sought or should have sought medical care during the 6 months immediately preceding coverage. Additionally, such a plan must waive any period applicable to a preexisting–condition exclusion or limitation that was satisfied under another plan, including medical assistance, under which the insured had coverage

to a date not less than 30 days before the effective date of coverage under the new plan.

The bill requires the commissioner to establish and administer a program to subsidize premiums for coverage under the basic plan. An individual or an employe, other than one eligible for medical assistance, would be eligible for a premium subsidy if he or she had a family income in the preceding year that was less than 200% of the poverty line for a family the size of his or her family. For an individual or an employe with a family income that did not exceed 100% of the poverty line, the amount of the premium subsidy would be 100% of the premium cost. For an individual or an employe with a family income of between 100% and 200% of the poverty line, the amount of the premium subsidy would be reduced from 100% of the premium cost by one percentage point for every percentage point that the individual's or employe's family income exceeded 100% of the poverty line.

Upon implementation of the basic plan, medical benefits will no longer be available under the general relief or relief of needy Indian persons programs, although agencies administering these programs are required to assist recipients under these programs in obtaining coverage and a premium subsidy under the basic plan. In addition, medical assistance benefits for covered persons will be limited to coverage under the basic plan or, in some cases, payment of medicare premiums, copayments and deductibles.

For further information see the ***state*** 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. 20.145 (9) of the statutes is created to read:

20.145 **(9)** BASIC HEALTH PLAN. (c) *Premium subsidies.* A sum sufficient for the premium subsidies under s. 637.27.

(i) *Recovery of premium subsidies.* All moneys received from the recovery, under s. 637.30 (2), of premium subsidies, for the payment of premium subsidies under s. 637.27.

SECTION 2. 20.435 (4) (eb) of the statutes is amended to read:

20.435 **(4)** (eb) *General relief aid.* The amounts in the schedule for state aid to counties for eligible general relief costs as determined under s. 49.035 ~~(4e) (a) and (b)~~.

SECTION 3. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** ~~Every~~ Except as provided in sub. (17), every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.87 (3) to (5), 632.895 (5m) and (8) to (10) and 632.896.

SECTION 4. 40.51 (9) of the statutes is amended to read:

40.51 **(9)** ~~Every~~ Except as provided in sub. (17), every health maintenance organization and preferred provider plan offered by the state under sub. (6) shall comply with s. 632.87 (2m).

SECTION 5. 40.51 (15m) of the statutes is amended to read:

40.51 **(15m)** ~~Every~~ Except as provided in sub. (17), every health care plan, except a health maintenance organization or a preferred provider plan, offered by the state under sub. (6) shall comply with s. 632.86.

SECTION 6. 40.51 (17) of the statutes is created to read:

40.51 **(17)** If one of the plans offered by the state under sub. (6) is the basic plan under ch. 637, that plan is required to comply with only those health insurance mandates, as defined in s. 601.423 (1), that the commissioner of insurance determines by rule under s. 637.05 (1) apply to the basic plan under ch. 637.

SECTION 7. 46.27 (11) (e) of the statutes is created to read:

46.27 **(11)** (e) Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), the department may not provide home and community–based services under this subsection to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 8. 46.275 (6) of the statutes is amended to read:

46.275 **(6)** EFFECTIVE PERIOD. This section takes effect on the date approved by the secretary of the ~~U.S.~~ federal department of health and human services as the beginning date of the period of waiver received under sub. (2). This section remains in effect for 3 years following that date and, if the secretary of the ~~U.S.~~ federal department of health and human services approves a waiver extension, shall continue an additional 3 years, except that, beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), the department may not provide services under this section to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 9. 46.278 (8) of the statutes is amended to read:

46.278 **(8)** EFFECTIVE PERIOD. Except as provided under sub. (2), this section takes effect on the date approved by the secretary of the federal department of health and human services as the beginning date of the period of waiver received under sub. (3). This section remains in effect for 3 years following that date and, if the secretary of the federal department of health and human services approves a waiver extension, shall continue an additional 3 years, except that, beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), the department may not provide services under this section to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 10. 49.002 (2) of the statutes is renumbered 49.002 (2) (a) and amended to read:

49.002 **(2)** (a) ~~It~~ Before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), it is the declared

legislative policy that general relief is the payer of last resort in all cases, except those cases involving crime victim awards under s. 949.06, where a dispute may arise over payment for costs associated with maintaining the health and welfare of recipients of general relief, including disputes concerning health care costs with private or public payees of health care costs, other governmental welfare programs, rehabilitation programs and programs requiring institutionalization or long–term medical and psychiatric treatment.

SECTION 11. 49.002 (2) (b) of the statutes is created to read:

49.002 **(2)** (b) Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), it is the declared legislative policy that general relief is the payer of last resort in all cases, except those cases involving crime victim awards under s. 949.06, where a dispute may arise over payment for costs associated with maintaining the welfare of recipients of general relief.

SECTION 12. 49.01 (5m) of the statutes is renumbered 49.01 (5m) (a) and amended to read:

49.01 **(5m)** (a) ~~"General~~ Before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), "general relief" means such services, commodities or ~~money~~ moneys as are reasonable and necessary under the circumstances to provide food, housing, clothing, fuel, light, water, medicine, medical, dental, and surgical treatment (including hospital care), optometrical services, nursing, transportation, and funeral expenses, and ~~include~~ includes wages for work relief. The food furnished shall be of a kind and quantity sufficient to provide a nourishing diet. The housing provided shall be adequate for health and decency. Where there are children of school age the general relief

furnished shall include necessities for which no other provision is made by law. The general relief furnished, whether by money or otherwise, shall be at such times and in such amounts, as will in the discretion of the general relief official or agency meet the needs of the recipient and protect the public.

SECTION 13. 49.01 (5m) (b) of the statutes is created to read:

49.01 **(5m)** (b) Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), "general relief" means such services, commodities or moneys as are reasonable and necessary under the circumstances to provide food, housing, clothing, fuel, light, water, transportation, and funeral expenses, and includes wages for work relief. The food furnished shall be of a kind and quantity sufficient to provide a nourishing diet. The housing provided shall be adequate for health and decency. Where there are children of school age the general relief furnished shall include necessities for which no other provision is made by law. The general relief furnished, whether by money or otherwise, shall be at such times and in such amounts, as will in the discretion of the general relief official or agency meet the needs of the recipient and protect the public.

SECTION 14. 49.015 (3) of the statutes is amended to read:

49.015 **(3)** ~~After December 31, 1986, a~~ A general relief agency may waive the requirement under sub. (1) (b) or (2) (a) ~~in a medical emergency or~~ in case of unusual misfortune or hardship. Before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), a general relief agency may also waive the requirement under sub. (1) (b) or (2) (a) in a medical emergency. Each waiver shall be reported to the department. The department may deny reimbursement under s. 49.035 for any case in which a waiver is inappropriately granted.

SECTION 15. 49.02 (5m) of the statutes is created to read:

49.02 **(5m)** Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), the general relief agency shall assist general relief recipients in applying for health care coverage under the basic plan under s. 637.05 and in applying for a premium subsidy under s. 637.27.

SECTION 16. 49.02 (20) of the statutes is created to read:

49.02 **(20)** Subsections (5), (6c), (6g), (6r), (8), (9) and (10) do not apply beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5).

SECTION 17. 49.032 (4r) of the statutes is amended to read:

49.032 **(4r)** If a general relief agency provides a monthly general relief benefit to an eligible dependent person which exceeds the monthly benefit amount required under sub. (1) (c), the department shall reimburse the general relief agency at the rate set forth under s. 49.035 (1) ~~(d)~~, from the appropriation under s. 20.435 (4) (eb), for the amount paid to the eligible dependent person.

SECTION 18. 49.035 (1) (intro.) and (d) of the statutes are consolidated, renumbered 49.035 (1) and amended to read:

49.035 **(1)** As provided in sub. (4e), the department shall reimburse, except for medical costs~~: (d) A~~, a county for up to 37.5% of the eligible costs paid by the general relief agency for general relief provided under s. 49.02.

SECTION 19. 49.035 (2) (b) 7. and 8. of the statutes are amended to read:

49.035 **(2)** (b) 7. Up to 40% of eligible medical costs that are incurred by the county before the first day of the 12th month beginning after the date on which the

department makes a certification under s. 49.44 (5), that are incurred on behalf of an individual client and that are not more than $10,000 per claim period.

8. Up to 70% of eligible medical costs that are incurred by the county before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), that are incurred on behalf of an individual client and that exceed $10,000 per claim period.

SECTION 20. 49.035 (2) (cm) (intro.) of the statutes is amended to read:

49.035 **(2)** (cm) (intro.) A county for up to 60% of the eligible medical costs that are incurred before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5) for individual clients who are enrolled in a prepaid health care system with a uniform fee per person, if the following requirements are met:

SECTION 21. 49.035 (4e) (a) and (b) of the statutes are amended to read:

49.035 **(4e)** (a) If claims for reimbursement of eligible general relief costs at the maximum rates under subs. (1) and (2) do not exceed the total of the funds available under s. 20.435 (4) (eb) and the payments to county hospitals and county mental health complexes under par. (c) for that fiscal year, the department shall determine the amount of a county's reimbursement from the appropriation under s. 20.435 (4) (eb) by applying the maximum rates under subs. (1) and (2) to the county's eligible costs and subtracting the amount paid to county hospitals and county mental health complexes in the county under par. (c).

(b) If claims for reimbursement of eligible general relief costs at the maximum rates under subs. (1) and (2) do exceed the total of the funds available under s. 20.435 (4) (eb) and the payments to county hospitals and county mental health complexes under par. (c) for that fiscal year, the department shall prorate the funds available

under s. 20.435 (4) (eb) among the counties. Under this paragraph, the department shall determine the amount of a county's reimbursement from the appropriation under s. 20.435 (4) (eb) by subtracting the amount paid to county hospitals and county mental health complexes in the county under par. (c) from its prorated share of the funds available under s. 20.435 (4) (eb).

SECTION 22. 49.035 (4e) (d) of the statutes is created to read:

49.035 **(4e)** (d) This subsection does not apply with respect to claims for reimbursement of eligible general relief costs that were incurred on or after the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5).

SECTION 23. 49.035 (6) (am) and (b) of the statutes are amended to read:

49.035 **(6)** (am) ~~Requires~~ Before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), requires prior authorization or health care provider certification for a specified period of time by the general relief agency for all nonemergency medical care that is provided.

(b) ~~Develops~~ Before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), develops and files with the department on or before October 1 of each year a medical cost containment plan for the subsequent calendar year. The plan shall include provisions limiting the inappropriate use of emergency room care and controlling payments to providers and may include provisions on supplying case management services. The department shall approve or disapprove the plan within a reasonable period of time after the plan is timely filed.

SECTION 24. 49.043 of the statutes is renumbered 49.043 (1) and amended to read:

49.043 **(1)** ~~Any~~ Except as provided in sub. (2), any municipality or county may purchase health or dental insurance for unemployed persons residing in the municipality or county who are not eligible for medical assistance under s. 49.46, 49.468 or 49.47.

SECTION 25. 49.043 (2) of the statutes is created to read:

49.043 **(2)** This section does not apply on or after the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5).

SECTION 26. 49.046 (3) (b) 1. to 3. of the statutes are consolidated, renumbered 49.046 (3) (b) 1 and amended to read:

49.046 (3) (b) 1. ~~Payments~~ Except as provided in subd. 2., payments for medical care may be made for any benefit authorized under s. 49.46 (2)~~. 2. Payments~~ and shall be equal to the rates established under s. 49.45. ~~3.~~ Recipients of aid for medical care are subject to the copayment provisions established under s. 49.45 (18).

SECTION 27. 49.046 (3) (b) 2. of the statutes is created to read:

49.046 **(3)** (b) 2. This paragraph does not apply with respect to payments for medical care incurred on or after the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5).

SECTION 28. 49.046 (4) (bm) of the statutes is created to read:

49.046 **(4)** (bm) Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), the administering agency shall assist recipients of aid under this section in applying for health care coverage under the basic plan under s. 637.05 and in applying for a premium subsidy under s. 637.27.

SECTION 29. 49.06 (3) of the statutes is renumbered 49.06 (3) (a) and amended to read:

49.06 **(3)** (a) ~~A~~ Except as provided in par. (b), a general relief agency may adopt written criteria to deny eligibility for general relief medical benefits to a person who, in contemplation of becoming eligible to receive general relief benefits, disposes of his or her assets for significantly less than full value during the 90 days immediately before the person applies for general relief medical benefits.

SECTION 30. 49.06 (3) (b) of the statutes is created to read:

49.06 **(3)** (b) This subsection does not apply after the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5).

SECTION 31. 49.43 (8) of the statutes is amended to read:

49.43 **(8)** "Medical assistance" means any services or items under ss. 49.45 to 49.47 and 49.49 to 49.497, or any payment or reimbursement made for such services or items, and, beginning on the first day of the 12th month beginning after the date on which the department makes a determination under s. 49.44 (5), coverage under the basic plan under s. 637.05 provided to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 32. 49.43 (10) of the statutes is amended to read:

49.43 **(10)** "Provider" means a person, corporation, limited liability company, partnership, unincorporated business or professional association and any agent or employe thereof who provides medical assistance ~~under ss. 49.45 to 49.47, 49.49 and 49.495~~, including, beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), any insurer

providing coverage under the basic plan under s. 637.05 to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 33. 49.44 of the statutes is created to read:

49.44 Basic health insurance plan waiver or legislation. (1) DEFINITIONS. In this section:

(a) "Basic plan" means the basic health care plan under s. 637.05.

(b) "Eligible person" means a person eligible to receive medical assistance.

(2) FEDERAL WAIVER. Except as provided in sub. (3), the department shall request a waiver, developed in consultation with and approved by the commissioner of insurance, from the secretary of the federal department of health and human services to allow the state to receive federal funding to provide health care coverage under the basic plan to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

(3) FEDERAL LEGISLATION. If the waiver request is denied, the department shall seek the enactment of federal legislation, developed in consultation with and approved by the commissioner of insurance, providing federal funding to the state to provide health care coverage under the basic plan to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

(5) CERTIFICATION BY DEPARTMENT. If the department determines that a waiver under sub. (2) is approved or legislation under sub. (3) is enacted, the department shall certify its determination to the commissioner of insurance on the first day of the first month beginning after the waiver is approved or the waiver is enacted.

(6) EFFECT OF CERTIFICATION. Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under sub. (5), from the appropriations under s. 20.435 (1) (b) and (o), medical assistance shall pay, for persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2., the premiums under s. 637.25 for coverage under the basic plan under s. 637.05 or, as provided in ss. 49.46 (2) (c) and (cm), 49.468 and 49.47 (6) (ag), medicare premiums, coinsurance and deductibles.

SECTION 34. 49.45 (8m) (intro.) of the statutes is amended to read:

49.45 **(8m)** RATES FOR RESPIRATORY CARE SERVICES. (intro.) Notwithstanding a determination by the department of a maximum rate under sub. (8), the rates under sub. (8) and rates charged by providers under s. 49.46 (2) (a) 4. d. that are not home health agencies, for reimbursement for respiratory care services for ventilator–dependent individuals under ss. 49.46 (2) (b) 6. m. and 49.47 (6) (a) ~~1.~~, shall be as follows:

SECTION 35. 49.45 (24m) (a) of the statutes is amended to read:

49.45 **(24m)** (a) By September 1, 1990, select a county in this state and solicit bids from providers of home health care and personal care services in that county for the provision, on a contractual basis, of home health and personal care services authorized under ss. 49.46 (2) (a) 4. d. and (b) 6. j. and 49.47 (6) (a) ~~1.~~

SECTION 36. 49.45 (37) (intro.) of the statutes is amended to read:

49.45 **(37)** PLANS OF CARE. (intro.) The department may seek a waiver of the requirement under 42 USC 1396n (c) (1) that the department review and approve every written plan of care developed for each individual who receives, under 42 USC 1396n (c) (1), home or community–based services under ss. 49.46 (2) (b) 8. and 49.47 (6) (a) ~~1.~~ The waiver of the requirement, if granted, shall apply to those county

departments or private nonprofit agencies that administer the services and that the department finds and certifies have implemented effective quality assurance systems for service plan development and implementation. If the federal health care financing administration approves the department's request for waiver of the requirement, the department shall, in evaluating a quality assurance system for certification, consider all of the following:

SECTION 37. 49.45 (50) of the statutes is created to read:

49.45 **(50)** APPLICABILITY. Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), subs. (2) (a) 9. to 14. and (b), (3) (b) to (k), (6b) to (9s), (13) to (16), (18), (20) to (22), (24) to (26), (29) to (32) and (35) to (37) do not apply with respect to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 38. 49.46 (2) (a) (intro.) of the statutes is amended to read:

49.46 **(2)** (a) (intro.) Except as provided in ~~par.~~ pars. (be) and (bm), the department shall audit and pay allowable charges to certified providers for medical assistance on behalf of recipients for the following federally mandated benefits:

SECTION 39. 49.46 (2) (b) (intro.) of the statutes is amended to read:

49.46 **(2)** (b) (intro.) Except as provided in ~~par.~~ pars. (be) and (bm), the department shall audit and pay allowable charges to certified providers for medical assistance on behalf of recipients for the following services:

SECTION 40. 49.46 (2) (bm) of the statutes is created to read:

49.46 **(2)** (bm) Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), benefits for an individual who is eligible for medical assistance under sub. (1) (a) 1., 1m., 6. or 12.,

(c), (cg), (co), (cr) or (cs) are limited to coverage under the basic plan under s. 637.05 or to the payment of medicare premiums, coinsurance and deductibles to the extent provided in pars. (c) and (cm).

SECTION 41. 49.465 (10) of the statutes is created to read:

49.465 **(10)** This section does not apply on or after the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5) with respect to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 42. 49.47 (6) (a) (intro.) of the statutes is renumbered 49.47 (6) (a) and amended to read:

49.47 **(6)** (a) ~~The~~ Except as provided in pars. (ag), (ar) and (as), the department shall audit and pay charges to certified providers for medical assistance services under s. 49.46 (2) (a) and (b) on behalf of ~~the following:~~ all medical assistance recipients eligible under sub. (4).

SECTION 43. 49.47 (6) (a) 1. of the statutes is repealed.

SECTION 44. 49.47 (6) (a) 6. of the statutes is renumbered 49.47 (6) (ag) and amended to read:

49.47 **(6)** (ag) 1. In this ~~subdivision: 1) "entitled~~ paragraph:

a. "Entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395f~~; 2) "entitled~~.

b. "Entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395L~~; and 3) "income~~.

c. "Income limitation" means income that is equal to or less than 100% of the poverty line, as established under 42 USC 9902 (2).

2. ~~An~~ For an individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare, meets the eligibility criteria under sub. (4) (a) and meets the income limitation, medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz ~~which~~ that are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums payable under 42 USC 1395v; the monthly premiums, if applicable, under 42 USC 1395i–2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

3. ~~An~~ For an individual who is only entitled to coverage under part A of medicare, meets the eligibility criteria under sub. (4) (a) and meets the income limitation, medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i ~~which~~ that are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums, if applicable, under 42 USC 1395i–2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare.

4. ~~An~~ For an individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and meets the eligibility criteria for medical assistance under sub. (4) (a) but does not meet the income limitation, medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz ~~which~~ that are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved

state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

5. ~~An~~ For an individual who is only entitled to coverage under part A of medicare and meets the eligibility criteria for medical assistance under sub. (4) (a), but does not meet the income limitation, medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i, including those services that are not included in the approved state plan for services under 42 USC 1396.

6. For an individual who is only entitled to coverage under part B of medicare and meets the eligibility criteria under sub. (4), but does not meet the income limitation, medical assistance shall ~~include payment of~~ pay the deductible and coinsurance portions of medicare services under 42 USC 1395j to 1395w, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

SECTION 45. 49.47 (6) (a) 6m. of the statutes is repealed.

SECTION 46. 49.47 (6) (a) 7. of the statutes is renumbered 49.47 (6) (ar) and amended to read:

49.47 **(6)** (ar) ~~Beneficiaries~~ For medical assistance recipients who are eligible under sub. (4) (a) 2. or (am) 1., medical assistance shall pay for services under s. 49.46 (2) (a) and (b) that are related to pregnancy, including postpartum and family planning services, or related to other conditions which may complicate pregnancy.

SECTION 47. 49.47 (6) (ag) 7. of the statutes is created to read:

49.47 **(6)** (ag) 7. For an individual who is entitled to coverage under part A of medicare, is entitled to coverage under part B of medicare and meets the eligibility criteria under sub. (4) (a) and whose income is greater than 100% of the poverty line but less than 120% of the poverty line, medical assistance shall pay the monthly premiums under 42 USC 1395r.

SECTION 48. 49.47 (6) (as) of the statutes is created to read:

49.47 **(6)** (as) Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), benefits for an individual who is eligible for medical assistance under sub. (4) (a) 1. or 2. are limited to coverage under the basic plan under s. 637.05 or to the payment of medicare premiums, coinsurance and deductibles to the extent provided in pars. (ag) and (ar).

SECTION 49. 49.47 (15) of the statutes is created to read:

49.47 **(15)** APPLICABILITY. Beginning on the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5), subs. (7) and (8) do not apply with respect to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or sub. (4) (a) 1. or 2.

SECTION 50. 49.475 (1) (a) of the statutes is amended to read:

49.475 **(1)** (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a)<u>, except that "disability insurance policy" does not include coverage under the basic plan under ch. 637</u>.

SECTION 51. 49.49 (7) of the statutes is created to read:

49.49 **(7)** APPLICABILITY. Subsections (3) to (4) do not apply with respect to offenses occurring on or after the first day of the 12th month beginning after the date

on which the department makes a certification under s. 49.44 (5) with respect to persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

SECTION 52. 613.03 (3) of the statutes is amended to read:

613.03 **(3)** APPLICABILITY OF INSURANCE LAWS. Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to subch. II of ch. 619 and ss. 610.01, 610.11, 610.21, 610.23 and 610.24 and chs. 600, 601, 609, 617, 620, 623, 625, 627, 628, 631, 632, 635, 637 and 645 and to no other insurance laws.

SECTION 53. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Subject to s. 637.25, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 637.25, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 54. 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. An insurer may itself establish rates and supplementary rate information for one or more market segments based on the factors in s. 625.12 and~~,~~ subject to s. 632.365 if the rates are for motor vehicle liability insurance~~, subject to s. 632.365,~~ or s. 637.25 if the rates are for coverage under the basic plan under ch. 637. In the alternative, the insurer may use rates and

supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

SECTION 55. 625.22 (1) of the statutes is amended to read:

625.22 **(1)** ORDER IN EVENT OF VIOLATION. If the commissioner finds after a hearing that a rate is not in compliance with s. 625.11 or 637.25, the commissioner shall order that its use be discontinued for any policy issued or renewed after a date specified in the order.

SECTION 56. 628.34 (3) of the statutes is amended to read:

628.34 **(3)** UNFAIR DISCRIMINATION. (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ~~s.~~ ss. 632.365 and 637.25. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

(b) No insurer may refuse to insure or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage because of a mental or physical disability except when the refusal, limitation or rate differential is based on either sound actuarial principles supported by reliable data or actual or reasonably anticipated experience, subject to ss. 637.20, 637.23 and 637.25.

SECTION 57. 628.36 (2) (b) 5. of the statutes is amended to read:

628.36 **(2)** (b) 5. Except for the small employer health insurance plan under subch. II of ch. 635 to the extent determined by the small employer insurance board under s. 635.23 (1) (b), and the basic plan under ch. 637 as determined by the commissioner under s. 637.05 (1), all health care plans, including health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87 (3).

SECTION 58. 632.70 of the statutes is amended to read:

632.70 (title) **Exemption for plan under ch. 635 or 637.** The health insurance mandates, as defined in s. 601.423 (1), that are provided under this subchapter apply to the small employer health insurance plan under subch. II of ch. 635 only to the extent determined by the small employer insurance board under s. 635.23 (1) (b), and to the basic plan under ch. 637 only as determined by the commissioner under s. 637.05 (1).

SECTION 59. 632.72 (1) of the statutes is renumbered 632.72 (1m).

SECTION 60. 632.72 (1c) of the statutes is created to read:

632.72 **(1c)** In this section, "policy of health and disability insurance" does not include a policy issued under the basic plan under ch. 637.

SECTION 61. 632.755 (2) of the statutes is renumbered 632.755 (2) (b).

SECTION 62. 632.755 (2) (a) of the statutes is created to read:

632.755 **(2)** (a) In this subsection, "disability insurance policy" does not include coverage under the basic plan under ch. 637.

SECTION 63. 635.01 of the statutes is renumbered 635.01 (1) and amended to read:

635.01 **(1)** ~~This~~ Except as provided in sub. (2), this subchapter applies to all group health insurance plans, policies or certificates, written on risks or operations

in this state, providing coverage for employes of a small employer, or employes of a small employer and the employer, and to individual health insurance policies, written on risks or operations in this state, providing coverage for employes of a small employer, or employes of a small employer and the employer when 3 or more are sold to a small employer.

SECTION 64. 635.01 (2) of the statutes is created to read:

635.01 **(2)** This subchapter does not apply to the basic plan under ch. 637.

SECTION 65. Chapter 637 of the statutes is created to read:

CHAPTER 637

BASIC HEALTH INSURANCE PLAN

637.01 Application. This chapter applies only if the department of health and social services makes a certification under s. 49.44 (5).

637.02 Definitions. In this chapter:

(1) "Abortion" means the use of any instrument, medicine, drug or any other substance or device with intent to terminate a pregnancy after implantation of a fertilized human ovum and with intent other than to increase the probability of a live birth, to preserve the life or health of the infant after live birth or to remove a dead fetus.

(2) "Community rate" means a uniform rate determined in such a manner that all insured individuals with the same level of coverage and plan design pay the same rate for that coverage, without regard to case characteristics or to loss or claim history, health condition, duration of coverage or other factors related to claims experience.

(3) "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full–time student under the age of 21 years and who is

financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(4) "Employe" includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, a member of a limited liability company and an independent contractor if the sole proprietor, business owner, partner, member or independent contractor is included as an employe under a health benefit plan of an employer.

(5) "Employer" means any of the following:

(a) An individual, firm, corporation, partnership, limited liability company or association that is actively engaged in a business enterprise in this state, including a farm business.

(b) The state.

(c) A municipality, as defined in s. 16.70 (8).

(6) "Medical assistance recipient" means a person entitled, under s. 49.44 (6), to coverage under the basic plan under s. 637.05.

(7) "Poverty line" means the poverty line as defined and revised annually under 42 USC 9902 (2).

(8) "Qualifying coverage" means benefits or coverage provided under any of the following:

(a) Medicare or medicaid.

(b) An employer–based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic plan.

(c) Except for a policy under the health insurance risk–sharing plan or an alternative plan under subch. II of ch. 619, an individual health insurance policy that

provides benefits similar to or exceeding benefits provided under the basic plan if the policy has been in effect for at least one year.

637.05 Basic plan. (1) The commissioner shall by rule design a health care plan that provides basic coverage of hospital, surgical and medical services and items. The basic plan shall provide both single and family coverage. The commissioner shall require a copayment of at least $2 for every service or item covered under the basic plan. The commissioner may by rule exempt the basic plan from any health insurance mandate, as defined in s. 601.423 (1).

(2) The commissioner shall administer the basic plan under this chapter and may promulgate rules relating to the operation and administration of the basic plan, including rules that are designed to reduce adverse selection, or the effects of adverse selection, in relation to the basic plan.

(3) The commissioner shall ensure that individuals and employers may obtain, and that medical assistance recipients shall receive, coverage under the basic plan no later than the first day of the 12th month beginning after the date on which the department of health and social services makes a certification under s. 49.44 (5).

637.10 Designating regions; selecting insurers. (1) The commissioner may divide the state into regions for the purpose of pooling individuals and employes with coverage under the basic plan if the commissioner determines that regional pools will result in more efficient and cost–effective delivery of health care coverage or services. The commissioner shall select insurers to provide coverage under the basic plan using a competitive sealed proposal process. Any insurer authorized to do a health insurance business in this state may submit a proposal to provide coverage under a basic health insurance plan that complies with this chapter, any

rules promulgated under this chapter and the terms of any waiver under s. 49.44 (2) or any legislation under s. 49.44 (3).

(2) An insurer selected by the commissioner shall comply with any requirements imposed by the commissioner related to the insurer's provision of coverage under the basic plan.

637.15 Coverage eligibility and entitlement. (1) Beginning on the first day of the 12th month beginning after the date on which the department of health and social services makes a certification under s. 49.44 (5), persons eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2. shall receive coverage, under s. 49.44 (6), under the basic plan.

(2) Beginning on the first day of the 12th month beginning after the date on which the department of health and social services makes a certification under s. 49.44 (5), all of the following are eligible to purchase coverage under the basic plan, subject to sub. (4):

(a) Any employer.

(b) Except as provided in sub. (3), any individual who is a resident of this state and who is not employed by an employer that offers coverage under the basic plan.

(3) An individual who, on the first day of the 12th month beginning after the date on which the department of health and social services makes a certification under s. 49.44 (5), has coverage under the health insurance risk–sharing plan under subch. II of ch. 619 or an alternative plan under s. 619.145 is not eligible for coverage under the basic plan.

(4) An employer or individual under sub. (2) who is covered under the basic plan and who voluntarily terminates that coverage is not again eligible for coverage

under the basic plan until 12 months have elapsed since the employer or individual last voluntarily terminated coverage under the basic plan.

637.20 Guaranteed issue. Subject to s. 637.15 (3) and (4), an insurer that is selected by the commissioner under s. 637.10 shall provide coverage, regardless of health condition or claims experience, to all of the following:

(1) To an employer and to any of the employer's employes and their dependents, if all of the following apply:

(a) The employer agrees to pay the premium required for coverage under the basic plan, less any subsidy for which an employe may be eligible under s. 637.27.

(b) The employer agrees to comply with all other provisions of the basic plan that apply generally to a policyholder or an insured without regard to health condition or claims experience.

(2) To any employe, and to the dependents of the employe, for whom an employer with coverage under the basic plan desires to provide coverage after the commencement of the employer's coverage, if the employer agrees to pay the required premium less any subsidy for which the employe may be eligible under s. 637.27.

(3) To an individual under s. 637.15 (2) (b) and his or her dependents, if all of the following apply:

(a) The individual agrees to pay the premium required for coverage under the basic plan, less any subsidy for which the individual may be eligible under s. 637.27.

(b) The individual agrees to comply with all other provisions of the basic plan that apply generally to a policyholder or an insured without regard to health condition or claims experience.

(4) To a person who is eligible for medical assistance under s. 49.46 (1) (a) 1., 1m., 6. or 12., (c), (cg), (co), (cr) or (cs) or 49.47 (4) (a) 1. or 2.

637.23 Preexisting conditions and portability. (1) The basic plan may not deny, exclude or limit benefits for a covered individual for losses incurred more than 12 months after the effective date of the individual's coverage due to a preexisting condition. The basic plan may not define a preexisting condition more restrictively than any of the following:

(a) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 12 months immediately preceding the effective date of coverage and for which the individual did not seek medical advice, diagnosis, care or treatment.

(b) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage.

(c) A pregnancy existing on the effective date of coverage, except that coverage may not be excluded for covered expenses related to such a pregnancy that exceed $5,000. Coverage not excluded may be subject to any deductibles or copayments that apply generally under the policy.

(2) Notwithstanding sub. (1), the basic plan may not deny, exclude or limit benefits for a covered individual or his or her dependents for losses incurred due to a preexisting condition if the individual is a person who receives coverage under the basic plan under s. 637.15 (1).

(3) (a) Notwithstanding sub. (1), the basic plan may not deny, exclude or limit benefits for a covered individual or his or her dependents for losses due to a preexisting condition if the individual applies for coverage during a 30–day enrollment period specified by the commissioner by rule under par. (b), provided that

an individual who is eligible for coverage under s. 637.15 (2) (b) has been a resident of this state for at least 6 months on the effective date of the individual's coverage.

(b) The commissioner shall by rule specify a biennial 30–day enrollment period during which individuals and their dependents may obtain coverage under the basic plan without any preexisting condition exclusion or limitation, as provided in par. (a).

(4) (a) The basic plan shall waive any period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period that an individual was previously covered by qualifying coverage that provided benefits with respect to such services, if the qualifying coverage terminated not more than 60 days before the effective date of the new coverage.

(b) Paragraph (a) does not prohibit the application of a waiting period to all new enrollees under the basic plan issued to an employer; however, a waiting period may not be counted when determining whether the qualifying coverage terminated not more than 60 days before the effective date of the new coverage. For the purpose of par. (a), the new coverage shall be considered effective as of the date that it would be effective but for the waiting period.

637.25 Premiums; community rates. (1) Except as provided in subs. (2) and (4), an insurer that provides coverage under the basic plan shall charge a community rate for such coverage.

(2) Subject to rate bands prescribed by the commissioner by rule, an insurer may modify the community rate under sub. (1) by taking into account the following factors:

(a) The insured's age.

(b) The insured's gender.

(c) The insured's geographic area.

(d) The insured's tobacco use.

(e) Whether the insured's coverage is single coverage or a type of family coverage.

(3) For each of the following factors, the rate bands prescribed by the commissioner by rule may not restrict the ratio of the highest variance to the lowest variance to a ratio that is less than the ratio shown after each factor:

(a) For age, a ratio of 2.5.

(b) For gender, a ratio of 1.2.

(c) For geographic area, a ratio of 1.2.

(4) Notwithstanding subs. (1) and (2), the commissioner may promulgate rules that permit an insurer to vary from the community rate required under sub. (1) and modified under sub. (2) within restrictions provided in the rules. The restrictions provided in the rules shall be reasonably designed to provide for an orderly transition to the community rates required under sub. (1) and modified under sub. (2) by no later than the first day of the 24th month beginning after the date on which the department of health and social services makes a certification under s. 49.44 (5).

(5) An employer may pay any portion or all of the premium, or the premium less a subsidy under s. 637.27, on behalf of an employe who is not a medical assistance recipient.

637.26 Abortion coverage. The basic plan may provide coverage for services related to the performance of an abortion only if any of the following applies:

(1) The abortion is directly and medically necessary to save the life of the woman or in a case of sexual assault or incest, provided that prior thereto the physician signs a certification which so states, and provided that, in the case of

sexual assault or incest the crime has been reported to the law enforcement authorities. The certification shall be affixed to the claim form or invoice when submitted to an insurer for payment, and shall specify and attest to the direct medical necessity of such abortion upon the best clinical judgment of the physician or attest to his or her belief that sexual assault or incest has occurred.

(2) The physician performing the abortion determines that, due to a medical condition existing prior to the abortion, the abortion is directly and medically necessary to prevent grave, long–lasting physical health damage to the woman, provided that prior thereto the physician signs a certification which so states. The certification shall be affixed to the claim form or invoice when submitted to an insurer for payment, and shall specify and attest to the direct medical necessity of such abortion upon the best clinical judgment of the physician.

637.27 Premium subsidies. (1) The commissioner shall establish and administer a program to subsidize, from the appropriations under s. 20.145 (9) (c) and (i), the premium cost for coverage under the basic plan for an individual other than a medical assistance recipient or for an employe whose employer provides coverage for the employe under the basic plan, if the individual or employe had a family income in the preceding year that was less than 200% of the poverty line for a family the size of the individual's or employe's family.

(2) Except as provided in rules promulgated under sub. (3) (d) to (f), for an individual or employe who is eligible for a subsidy under sub. (1) and whose family income in the preceding year did not exceed 100% of the poverty line for a family the size of the individual's or employe's family, the subsidy amount shall be 100% of the cost of coverage under the basic plan. Except as provided in rules promulgated under sub. (3) (d) to (f), for all other individuals or employes who are eligible for a subsidy

under sub. (1), the subsidy amount shall be reduced from 100% of the cost of coverage by one percentage point for every percentage point that the individual's or employe's family income in the preceding year exceeded 100% of the poverty line for a family the size of the individual's or employe's family.

(3) The commissioner shall promulgate rules that do all of the following:

(a) Define family income for purposes of this section.

(b) Specify how an individual, employe or employer may provide satisfactory evidence of family income to the insurer providing coverage under the basic plan for the individual or employe.

(c) Establish procedures for paying subsidies to insurers for the cost of coverage under the basic plan for individuals or employes eligible for a subsidy under this section.

(d) Establish asset–based eligibility criteria for premium subsidies under this section.

(e) Limit an individual's eligibility for premium subsidies under this section for specified periods, if the individual transfers assets or income for less than fair market within a specified period prior to applying for a premium subsidy under this section.

(f) Provide for reducing or eliminating premium subsidies under this section for violations of this chapter or of rules promulgated under this chapter.

(g) Provide for the recovery of premium subsidies paid under this section, if the family income of a recipient of a premium subsidy increases above the level at which the recipient is eligible for a premium subsidy under this section.

637.30 Commissioner duties. The commissioner shall do all of the following:

(1) Enter into contracts with insurers selected under s. 637.10 to provide coverage under the basic plan.

(2) After reasonable notice and opportunity for hearing, recover premium subsidies paid under s. 637.27 that are improperly or erroneously paid, by offsetting or adjusting amounts owed to the insurer under this chapter, by crediting against an insurer's future claims for premium subsidies or by requiring the insurer to make direct payment to the commissioner. Any moneys received under this subsection shall be credited to the appropriation under s. 20.145 (9) (i).

(3) Review the statutory provisions governing the provision of coverage under the basic plan to medical assistance recipients and, if the commissioner determines that remedial legislation is required, submit proposed remedial legislation to the appropriate standing committees of the legislature under s. 13.172 (3), no later than the first day of the first floorperiod ending before the first day of the 12th month beginning after the date on which the department makes a certification under s. 49.44 (5).

SECTION 66. Initial applicability.

(1) BASIC PLAN PREMIUM SUBSIDIES. The treatment of sections 20.145 (9) (c) and (i) and 637.27 of the statutes first applies to subsidies for premiums for coverage under the basic plan that commences on the first day of the 12th month beginning after the date on which the department of health and social services makes a certification under section 49.44 (5) of the statutes, as created by this act.

(END)