LRBb0577

1999 DRAFTING REQUEST

Assembly Amendment (AA-AB133)

Received: **06/7/99**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Legislative Fiscal Bureau 6-3847**

By/Representing: **Goldman**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Pre Topic:

LFB:......Goldman -

Topic:

Modifications to HIRSP

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 06/10/99	jgeller 06/11/99		_______ _______			
/1			martykr 06/11/99	_______ _______	lrb_docadmin 06/11/99		
/2	kahlepj 06/11/99	gilfokm 06/11/99	martykr 06/12/99	_______ _______	lrb_docadmin 06/12/99		
/3	kahlepj 06/14/99	gilfokm 06/14/99	martykr 06/14/99	_______ _______	lrb_docadmin 06/14/99		

Vers.	Drafted	Reviewed	Typist	Proofed	Submitted	Jacketed	Required
/4	kahlepj 06/14/99	gilfokm 06/14/99	mclark 06/14/99	_______ _______	lrb_docadmin 06/15/99		
/5	kahlepj 06/15/99	jgeller 06/15/99	mclark 06/15/99	_______ _______	lrb_docadmin 06/15/99		

FE Sent For:

<END>

1999 DRAFTING REQUEST

Assembly Amendment (AA-AB133)

Received: **06/7/99** | Received By: **kahlepj**

Wanted: **Soon** | Identical to LRB:

For: **Legislative Fiscal Bureau 6-3847** | By/Representing: **Goldman**

This file may be shown to any legislator: **NO** | Drafter: **kahlepj**

May Contact: | Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous | Extra Copies:

Pre Topic:

LFB:......Goldman -

Topic:

Modifications to HIRSP

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 06/10/99	jgeller 06/11/99		_______ _______			
/1			martykr 06/11/99	_______ _______	lrb_docadmin 06/11/99		
/2	kahlepj 06/11/99	gilfokm 06/11/99	martykr 06/12/99	_______ _______	lrb_docadmin 06/12/99		
/3	kahlepj 06/14/99	gilfokm 06/14/99	martykr 06/14/99	_______ _______	lrb_docadmin 06/14/99		
		/5 6/15 jlg	mrc 6/15	mrc/cmh 6/15			

Vers.	Drafted	Reviewed	Typist	Proofed	Submitted	Jacketed	Required
/4	kahlepj 06/14/99	gilfokm 06/14/99	mclark 06/14/99	_______ _______	lrb_docadmin 06/15/99		

FE Sent For:

<END>

1999 DRAFTING REQUEST

Assembly Amendment (AA-AB133)

Received: **06/7/99**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Legislative Fiscal Bureau 6-3847**

By/Representing: **Goldman**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Pre Topic:

LFB:......Goldman -

Topic:

Modifications to HIRSP

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 06/10/99	jgeller 06/11/99					
/1			martykr 06/11/99		lrb_docadmin 06/11/99		
/2	kahlepj 06/11/99	gilfokm 06/11/99	martykr 06/12/99		lrb_docadmin 06/12/99		
/3	kahlepj 06/14/99	gilfokm 06/14/99	martykr 06/14/99		lrb_docadmin 06/14/99		

/4-6-14-99 mRC 6/14 mee/ctt 6/14

FE Sent For:

<END>

1999 DRAFTING REQUEST

Assembly Amendment (AA-AB133)

Received: **06/7/99**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Legislative Fiscal Bureau 6-3847**

By/Representing: **Goldman**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Pre Topic:

LFB:......Goldman -

Topic:

Modifications to HIRSP

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 06/10/99	jgeller 06/11/99		_______ _______			
/1			martykr 06/11/99	_______ _______	lrb_docadmin 06/11/99		
/2	kahlepj 06/11/99	gilfokm 06/11/99	martykr 06/12/99	_______ _______	lrb_docadmin 06/12/99		

FE Sent For: /3-6-14-99 km 6/14 km 6/14

<END>

1999 DRAFTING REQUEST

Assembly Amendment (AA-AB133)

Received: **06/7/99**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Legislative Fiscal Bureau 6-3847**

By/Representing: **Goldman**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Pre Topic:

LFB:......Goldman -

Topic:

Modifications to HIRSP

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 06/10/99	jgeller 06/11/99		_______ _______			
/1		/2-6-11-99 kmg	martykr 06/11/99 Km 6/12	_______ _______ JJ 6 Km 12	lrb_docadmin 06/11/99		

FE Sent For:

<END>

LRBb0577

1999 DRAFTING REQUEST

Assembly Amendment (AA-AB133)

Received: **06/7/99**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Legislative Fiscal Bureau 6-3847**

By/Representing: **Goldman**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Pre Topic:

LFB:......Goldman -

Topic:

Modifications to HIRSP

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj	/1 6/10 jg	km 6/11	js km 6/11			

FE Sent For:

<END>

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

June 7, 1999 | Joint Committee on Finance | Paper #510

Health Insurance Risk-Sharing Plan (DHFS)

[LFB 1999-01 Budget Summary: Page 283, #1 (part)]

CURRENT LAW

The state's health insurance risk-sharing plan (HIRSP) was created in 1980 to provide comprehensive health insurance coverage for the state's medically uninsurable population. Prior to January 1, 1998, HIRSP was governed by the HIRSP Board of Governors ("the Board") and administered by the Office of the Commissioner of Insurance (OCI). The program was funded by policyholder premiums and financial assessments on health insurance companies that do business in Wisconsin. OCI contracted with Blue Cross & Blue Shield United of Wisconsin to administer the plan. The plan administrator is responsible for the ongoing operational activities of the program, such as: (a) performing application and eligibility functions; (b) processing, evaluating and paying health care provider claims; and (c) providing customer service to enrollees.

1997 Wisconsin Act 27 made a number of significant changes to HIRSP, including: (a) transferring the program from OCI to the Department of Health and Family Services (DHFS); (b) requiring health care providers who provide services to enrollees to share equally in program costs that are not covered by policyholders and state funding; (c) providing $6.0 million GPR in 1999-00 and $11.9 million GPR in 2000-01 to support program costs; and (d) requiring the plan administrator to be the same entity as the medical assistance (MA) fiscal agent [currently Electronic Data Systems (EDS)].

Act 27 also reduced the Board's authority so that the Board functions as an advisory board, rather than a governing board. However, the Board retained its authority to: (a) establish grievance procedures; (b) collect assessments from insurers; (c) develop and implement a program to advertise the plan and its eligibility requirements; and (d) establish payment rates for covered services.

HIRSP premiums are required to cover 60% of the projected operating and administrative cost of the program after GPR funds are deducted from the total costs. However, DHFS may not

establish premium rates that are less than 150% or more than 200% of the rate that would be charged under an individual policy that provides substantially the same coverage and deductibles as HIRSP provides ("the standard rate"). After the amounts projected to be available from enrollee premiums and the new GPR appropriation have been deducted from the estimated costs of the program, the unfunded costs are covered in the following manner: (a) 50% of the amount is assessed against health insurers writing health insurance in the state; and (b) 50% of the amount is acquired by reducing the rate of reimbursement to providers for health care services provided to HIRSP enrollees.

GOVERNOR

Decrease GPR support for HIRSP by $2,000,000 annually so that $9,900,000 GPR annually would be available to partially support HIRSP in the 1999-01 biennium.

Specify that the Board would advise DHFS on, but no longer be responsible for, all of the following: (a) establishing grievance procedures; (b) collecting assessments from insurers; (c) developing and implementing a program to advertise the plan and its eligibility requirements; and (d) establishing payment rates for covered services. Delete the Board's authority to adjust provider payment rates. Consequently, DHFS, rather than the Board, would be responsible for these activities, although the Board would have an advisory role.

DISCUSSION POINTS

1. In fiscal year 1997-98, the Legislative Audit Bureau (LAB) conducted an audit of HIRSP for state fiscal year 1997-98. The audit was published in April, 1999. The audit states that the way in which DHFS accounted for health care contributions did not allow the Department to determine whether DHFS had met the statutory funding requirements from January through June, 1998, and that policyholders and providers have experienced problems with the new plan administrator. The audit also identified higher than anticipated plan administration costs for the program subsequent to its transfer to DHFS and the new plan administrator. According to the audit, the ongoing monthly service costs for the plan administrator are 80% greater for EDS than they were under the Blue Cross & Blue Shield contract.

2. On May 4, 1999, DHFS Secretary Leean submitted a number of proposed changes to HIRSP for the Committee's consideration. These proposed changes were submitted with the concurrence of the Department of Administration. The Department's proposal includes recommended statutory changes to improve the overall administration of the program, including the required annual reconciliation process and a request for additional position authority to address increased workload associated with the administration of HIRSP. The Department's proposed statutory changes are summarized in the Appendix to this paper. The DHFS proposal has been approved in concept by the Board and it appears to address many of the issues raised in the LAB audit.

3. The proposed statutory modification would improve the administration of the program in a number of ways. First, the proposed changes would ensure that the Department was able to meet the statutory funding requirements. Second, the proposed changes would improve the fiscal accountability of the program. Currently, HIRSP operational costs are not reflected in the state budget. There are no state appropriations for HIRSP benefit and administrative costs. As a result, the program is administered "off the books." The Department's proposed changes include the creation of HIRSP appropriations so that the entire program would be reflected in the Department's appropriation structure and the state accounting system. The inclusion of the program in the state's accounting system would also permit the State of Wisconsin Investment Board to invest program revenues. Finally, the proposed changes would improve administration of the program by streamlining and improving the efficiency of the HIRSP pharmacy reimbursement system.

4. Concerns have been raised about significantly increased HIRSP administrative costs and the reduction of HIRSP Board authority under Act 27 and the budget bill. HIRSP administrative costs have increased under DHFS management. In 1999-00, plan administrator costs are projected to total approximately $3.1 million, compared to $1.7 million paid to Blue Cross & Blue Shield in calendar year 1997. In addition, under the DHFS proposal, state staff responsible for HIRSP would increase from 1.5 FTE to 4.0 FTE and 1.0 project position at an estimated cost of $140,600 in 1999-00 and $158,900 in 2000-01. OCI was authorized 1.5 SEG positions and $94,600 annually to provide administrative support to the Board and to serve as a liaison between the agency and the plan administrator. These positions were transferred to DHFS as part of Act 27.

5. The Department indicates that it has reallocated staff in such a way that a total 4.0 positions are currently working on the administration and management of HIRSP. The Department has also indicated that this reallocation is not sustainable because of the Department's new responsibilities related to BadgerCare and Family Care in the next biennium.

The existing 1.5 SEG position, in addition to 3.0 SEG requested positions, would be responsible for the following activities: (a) developing and implementing grievance procedures; (b) staffing the Board's grievance committee; (c) developing cost containment policies, initiatives and budget proposals; (d) drafting administrative rules; (e) writing directives for the plan administrator; (f) staffing Board meetings and Board subcommittees; (g) developing reports required by the Board; (h) conducting the annual reconciliation process; (i) monitoring the daily operations of the plan administrator; and (j) responding to written and oral questions and complaints from policyholders that cannot be handled by the plan administrator. Under current law, the Board is responsible for establishing grievance procedures. The additional .5 SEG requested position would function as an accountant for the HIRSP program. Therefore, under the Department's proposal, a total of 5.0 SEG positions would be authorized to support the state administration of HIRSP.

6. While DHFS has had to reallocate positions in order to manage HIRSP-related workload in the last year, much of this workload was related to the transition of program management and initial implementation issues. The program has become more complicated as a result of the funding mechanism provided in Act 27. However, these complexities have also been addressed by increasing staff resources for the plan administrator. Taking into consideration

increased plan administrator expenses as a result of hiring additional staff and the fact that the plan administrator is responsible for virtually all operational functions of HIRSP, it is not clear that an additional 3.5 staff positions in DHFS are justified.

7. The audit also found that DHFS, as a result of addressing service needs, has been delayed in providing program oversight in several administrative and management areas. The audit also suggests that administrative costs may have increased because the contract with Blue Cross & Blue Shield was competitively negotiated, while a competitive process was not possible for the EDS contract because of the Act 27 provision that requires the HIRSP plan administrator to be the state's MA fiscal agent. The audit suggests that in the absence of a competitive administrative contracting process, it would be important for DHFS to take steps to manage costs and establish performance contracts. The Department is currently developing performance standards for the plan administrator and financial penalties for failure to meet these standards. These performance standards would include requirements for the following: (a) monthly, quarterly and annual reports; (b) claims processing; (c) application processing; (d) quality assurance; (e) customer service; and (f) budget implementation. It could be argued that as a result of these increased contract monitoring responsibilities, the administration of HIRSP under current law requires more resources than were necessary prior to the Act 27 modifications.

8. Prior to Act 27, the operation of HIRSP was subject to the general supervision and approval of the Board. The Board's statutory duties and responsibilities included: (a) selecting and contracting with an administrating carrier for the plan; (b) setting and collecting assessments of participating insurers to cover any plan deficits; (c) establishing a payment rate for covered plan expenses, which was 10% less than the usual and customary rate approved for payment under the administrating carrier; (d) publicizing the availability of the plan; (e) establishing procedures under which applicants and participants may have grievances reviewed by an impartial body; and (f) reporting annually to the Legislature on the operation of the plan, including the cost burden imposed by the plan on all health insurance policyholders in the state.

9. Under the Act 27 modifications and the provisions in Assembly Bill 133, the Board would have virtually no authority related to the administration and management of HIRSP. The reduction of Board authority in Act 27 coincided with the commitment of state funding for HIRSP. At the time, it was argued that the state, through DHFS, should have direct control over the administration of HIRSP, as a result of the state's financial commitment to the program. In addition, DHFS was given more authority over the program because the Department was charged with stabilizing the program, controlling program costs and integrating the administration of the program with the administration of the MA program.

10. In 1999-00, it is expected that the GPR provided for HIRSP would reduce the total cost of the program by approximately 20%. Therefore, approximately 80% of the costs of HIRSP are born by policyholders, insurers and health care providers. In addition, because state funding for HIRSP is budgeted at a fixed amount, the state is held harmless for any increase in HIRSP operating or administrative costs. These increased costs must be supported by policyholders, insurers and health care providers, each of whom is represented on the Board. Therefore, it could be argued that

these entities have a vested interest in controlling HIRSP program costs and should have authority over policy decisions that relate to HIRSP program and administrative costs. Requiring Board approval of the HIRSP budget and the plan administrator contract would provide the Board with increased oversight authority over important issues, such as the appropriate level of a cash reserve for the plan. DHFS could also be required to obtain Board approval before implementing cost containment procedures that would affect policyholder's access to health care services, such as the creation of new prior authorization requirements.

11. A number of parties have also raised concerns about the reduction of GPR support for the HIRSP program. In the Executive Budget Summary, the administration states that the purpose of the funding reduction is to "encourage the use of cost containment strategies." Under the Department's proposal, DHFS would have increased authority to implement cost containment strategies, such as requiring prior authorization for particular services and denying coverage for others, such as drugs for infertility treatment. Estimated 1999-00 HIRSP program costs, excluding premium subsidy costs, are approximately $1.8 million higher than 2000-01. However, the 2000-01 budget does not reflect savings that may be achieved as a result of the proposed cost containment strategies.

12. Prior to Act 27, other than premium subsidies, the state did not fund a share of the ongoing operating costs of HIRSP. State funding was provided, beginning January 1, 1998, to reduce the financial burden of the plan on policyholders, insurers and health care providers. Because state funds are deducted from the estimated costs of the program prior to establishing premiums, insurer assessments and provider discounts, any reduction in state funding for the program would necessarily increase the costs for premium payers, insurers and providers.

13. The original amount of state funding for HIRSP was not based on a formula that considered overall program costs or the number or policyholders. Instead, it represented the amount of funding that the Legislature determined was appropriate after considering other budget priorities. Therefore, the Committee could review the level of state funding for HIRSP in the context of the current budget and its current funding priorities and modify the amount of GPR funding provided to support plan costs.

ALTERNATIVES

A. Statutory Modifications

1. Adopt the statutory modifications in the bill relating to the authority of the Board.

2. In addition to the statutory modifications in the bill, adopt one or more of the following:

a. Modify the bill by adopting the statutory changes proposed by the Department, except provisions relating to DHFS staff, as summarized in the Appendix to this paper.

412

b. Require DHFS to obtain approval of the Board before implementing the HIRSP annual budget and the plan administrator contract. Finally, require DHFS to obtain approval of the Board before implementing cost containment procedures that would affect policyholder's access to health care services, such as the creation of new prior authorization requirements.

c. In addition, provide $46,668,500 SEG annually to support HIRSP benefits and $3,664,400 SEG in 1999-00 and $3,646,100 in 2000-01 to support HIRSP administration.

Alternative A2c	SEG
1999-01 FUNDING (Change to Bill)	$100,647,500

3. Maintain current law.

B. Funding Alternatives -- Program Operations

1. Adopt the Governor's recommendation to reduce funding by $2.0 million GPR annually so that $9.9 million GPR annually would be available to support HIRSP programs costs.

2. Maintain base GPR support for the program by deleting the Governor's funding recommendation.

Alternative B2	GPR
1999-01 FUNDING (Change to Bill)	$4,000,000

3. Increase GPR support for the program by one of the following:

	1999-00	2000-01
a.	$1,000,000	$1,000,000
b.	$2,000,000	$2,000,000
c.	$3,000,000	$3,000,000
d.	$4,000,000	$4,000,000
e.	$5,000,000	$5,000,000

4. Decrease GPR support for the program by one of the following:

	1999-00	2000-01
a.	-$1,000,000	-$1,000,000
b.	-$2,000,000	-$2,000,000
c.	-$3,000,000	-$3,000,000
d.	-$4,000,000	-$4,000,000
e.	-$5,000,000	-$5,000,000

5. Delete all base GPR support for the program.

Alternative B5	GPR
1999-01 FUNDING (Change to Bill)	- $19,800,000

C. State Administrative Staff

1. Provide $41,000 SEG in 1999-00 and $47,500 SEG in 2000-01 and 1.0 SEG position, beginning in 1999-00.

Alternative C1	SEG
1999-01 FUNDING (Change to Bill)	$88,500
2000-01 POSITIONS (Change to Bill)	1.00

2. Provide $82,000 SEG in 1999-00 and $85,200 SEG in 2000-01 and 2.0 positions, beginning in 1999-00.

Alternative C2	SEG
1999-01 FUNDING (Change to Bill)	$167,200
2000-01 POSITIONS (Change to Bill)	2.00

KG 3. Provide $140,600 SEG in 1999-00 and $158,900 SEG in 2000-01 and 2.5 SEG positions, beginning in 1999-00, and 1.0 project position that would expire June 30, 2001.

Alternative C3	SEG
1999-01 FUNDING (Change to Bill)	$219,500
2000-01 POSITIONS (Change to Bill)	3.50

4. Maintain current law.

Prepared by: Amie T. Goldman

APPENDIX

DHFS Proposed Statutory Changes

HIRSP Fund. Specify that the HIRSP fund would be comprised of all monies received from: (a) insurance assessments for program costs, excluding payments for premium subsidies; (b) all premiums received from policyholders; and (c) the GPR appropriations for HIRSP costs and premium and deductible subsidies. Authorize the Investment Board to invest monies from the HIRSP fund.

Appropriation Changes and Position Authority. Transfer 0.5 SEG position and $40,500 annually from the HIRSP administration appropriation to the DHFS general administration and support services appropriation. This .5 position would be an accountant for the HIRSP program.

Convert the annual HIRSP administration appropriation from an annual to a biennial appropriation and provide $3,664,400 SEG in 1999-00 and $3,646,100 SEG in 2000-01. Renumber the HIRSP premium reduction appropriation, convert the appropriation to a continuing SEG appropriation and rename the appropriation "HIRSP program benefits funding."

Provide $46,668,500 SEG annually in the program benefits appropriation to support HIRSP program benefits costs. Require DHFS to separately account for premium revenues, within this appropriation, which represent the difference between the amount of premiums collected from policyholders and the amount of premiums that are required to support 60% of the plan costs. Specify that monies received in this separate allocation could be used to: (a) reduce policyholder premiums in future years, but not to reduce premiums below 150% of the standard rate; or (b) for other policyholder needs with majority approval by the Board. Under current law, these monies may only be used to subsidize premiums. Replace statutory references to the HIRSP premium reduction appropriation with references to the monies allocated for premium reductions within the program benefits appropriation. Direct DHFS to establish a separate allocation for funds to support program benefits.

HIRSP Coverage. Authorize DHFS to establish rates for the various provider groups based on changes in MA reimbursement rates, projected plan costs and trend factors. Require DHFS to create HIRSP-specific outpatient per visit reimbursement rates and inpatient rates based on diagnostic related groups with outlier protections similar to MA. Specify that pharmacists would receive MA reimbursement for drugs under HIRSP and that DHFS would pay physicians and other health care professionals at an enhanced MA rate. The enhanced rate would be the maximum allowable reimbursement under MA for a particular service plus an additional amount determined by DHFS.

Authorize DHFS to apply MA utilization and cost control procedures to HIRSP, as specified by MA rules. For example, these rules require prior authorization for outpatient psychotherapy services in excess of: (a) $500 per recipient per calendar year for service provided by hospital-based providers; and (b) $500 or 15 hours per recipient per calendar year for services provided by non-hospital-based providers. In addition, authorize DHFS to apply MA service and coverage policies to HIRSP coverage of services and procedures related to impotence and infertility.

Prohibit DHFS from applying MA copayments to HIRSP enrollees.

Pharmaceuticals. Authorize DHFS to establish copayments for prescription drug coverage and to establish the level of the copayment. Specify that prescription drug copayments would be counted toward HIRSP enrollees deductibles and total out of pocket expenditures under the plan. DHFS estimates that the copayment would be $12 per prescription.

Authorize DHFS to elect to cover and reimburse drugs under HIRSP only if claims are submitted directly by pharmacies to the HIRSP plan administrator. Authorize DHFS to require pharmacies that participate in HIRSP to bill the plan administrator directly for drug reimbursement. This requirement should reduce administrative costs for the program as a result of streamlining the claims submission and reducing the number of claims that must be processed manually.

Payment of Plan Costs and Annual Reconciliation Process. Require DHFS to conduct an annual reconciliation process. DHFS would base the reconciliation on calendar year data and would implement any necessary adjustments to premiums, insurance assessments and provider reimbursement rates resulting from the reconciliation in the subsequent fiscal year. Require DHFS to conduct the annual reconciliation by April 30 in each year.

Specify that the provider's share of total HIRSP costs would be calculated once annually and would consider all provider groups in the aggregate, rather than on a provider by provider basis. Delete statutory provisions relating to Board authority to advise DHFS on establishing payment rates under HIRSP. This provision is obsolete due to the new mechanism for establishing provider payments under the Act 27 modifications.

Effective Date. Specify that the effective date of these provisions would be January 1, 2000.

0412

Representative Albers

HEALTH AND FAMILY SERVICES

Health Insurance Risk-Sharing Plan (HIRSP)

Motion:

Move to adopt alternatives A2 (a), A2 (b), A2 (c) and C3 with the following modifications: (a) delete provisions from the bill that would reduce the Board's authority relating to establishing grievance procedures, collecting assessments from insurers, developing and implementing a program to advertise the plan and establishing payment rates for covered services; (b) require DHFS to obtain approval of the Board for the amount of the drug copayment authorized for HIRSP enrollees under the motion; and (c) require the Board to establish oversight committees to address various HIRSP administrative issues, such as financial management of the plan and plan administrator performance standards. Specify that the chairperson of these committee could not be a representative of DHFS. Finally, specify that the effective date of these modifications would be the general effective date of the bill. The effective date of the statutory changes proposed by DHFS would be January 1, 2000.

Note:

Under this motion, the Department's proposed statutory changes for the program would be adopted with a number of modifications that would expand the Board's oversight authority over HIRSP operations and administration. In addition, DHFS would be authorized 2.5 SEG positions and 1.0 SEG project position, expiring June 30, 2001, to provide additional support for the administration of HIRSP.

[Change to Bill: $100,867,000 SEG]

MO# Albers

Burke	Y	N
Decker	Y	N
Jauch	Y	N
Moore	Y	N
Shibilski	Y	N
Plache	Y	N
Cowles	Y	N
Panzer	Y	N
Gard	Y	N
Porter	Y	N
Kaufert	Y	N
Albers	Y	N
Duff	Y	N
Ward	Y	N
Huber	Y	N
Riley	Y	N

16-0 passes

Motion #1201

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement. (1) A State plan under this title [42 USCS §§ 1396 et seq.] shall not be considered to meet the requirement of section 1902(a)(13)(A) [42 USCS § 1396a(a)(13)(A)] (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirement of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) [42 USCS § 1396a(a)(13)(A)] as of July 1, 1989, the State must submit to the Secretary of Health and Human Services by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) [42 USCS § 1396a(a)(13)(A)] as of July 1, 1990, the State must submit to the Secretary of Health and Human Services by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this title [42 USCS §§ 1396 et seq.] provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) [42 USCS § 1396a(a)(13)(A)] as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) of this section or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology -

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI of this chapter, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10) of this section, methodology is considered to be ''no more restrictive'' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

42 USC 1396a

(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years

In order to meet the requirements of subsection (a)(55) (FOOTNOTE 61) of this section, the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1396r-4(b)(1) of this title, shall -

(FOOTNOTE 61) So in original. Probably should be subsection ''(a)(56)''.

(1) if made on a prospective basis (whether per diem, per case,

or otherwise) provide for an ***outlier*** adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Limitation on payments to States for expenditures attributable to taxes

Nothing in this subchapter (including sections 1396b(a) and 1396d(a) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u) Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals -

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved,

(C) whose resources (as determined under section 1382b of this

149.143(1)(b)1.a.
a. First, from premiums from eligible persons with coverage under s. 149.14 set at 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan, including amounts received for premium and deductible subsidies under **ss. 20.435** (5) (ah) and 149.144, and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

149.143(1)(b)1.c.
c. Third, by increasing premiums from eligible persons with coverage under s. 149.14 to more than 150% but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan, including amounts received for premium and deductible subsidies under **ss. 20.435** (5) (ah) and 149.144, and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay 60% of plan costs.

149.143(2)(a)1.a.
a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under **ss. 20.435** (5) (ah) and 149.144 and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60% of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available in the appropriation under s. 20.435 (5) (af) for that plan year.

149.143(1)(a)
(a) First from the appropriation under **s. 20.435** (5) (af).

149.143(1)(b)1.b.
b. Second, from the appropriation under **s. 20.435** (5) (gh), to the extent that the amounts under subd. 1. a. are insufficient to pay 60% of plan costs.

149.143(2)(a)1.a.
a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under ss. 20.435 (5) (ah) and 149.144 and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60% of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available in the appropriation under **s. 20.435** (5) (af) for that plan year.

149.143(2)(a)1.c.
c. If the amount estimated to be received under subd. 1. a. is less than the amount estimated to be received under subd. 1. b., direct the plan administrator to provide to the department, prior to the beginning of the plan year and according to procedures specified by the department, the amount of the difference. The department shall deposit all amounts received under this subd. 1. c. in the appropriation account under **s. 20.435** (5) (gh).

149.144
149.144 Adjustments to insurer assessments and provider payment rates for premium and deductible reductions. If the moneys under **s. 20.435** (5) (ah) are insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), or the department determines that the moneys under **s. 20.435** (5) (ah) will be insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), the department shall, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to s. 149.143 (1) (b) 1., sufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a). The department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

149.165(4)
(4) The department shall reimburse the plan for premium reductions under sub. (2) and deductible reductions under s. 149.14 (5) (a) with moneys from the appropriation under **s. 20.435** (5) (ah).

State of Wisconsin
1999 – 2000 LEGISLATURE

LRBb0577/1
PJK.......

LFB:......Goldman – Modifications to HIRSP

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

LFB AMENDMENT

TO 1999 ASSEMBLY BILL 133 AND 1999 SENATE BILL 45

1 At the locations indicated, amend the bill as follows:

2 **1.** Page 420, line 20: delete that line and substitute:

3 "**SECTION 386b.** 20.435 (1) (u) of the statutes is renumbered 20.435 (4) (u) and

4 amended to read:

5 20.435 **(4)** (u) *Health insurance risk–sharing plan; administration.* ~~The~~

6 Biennially, from the health insurance risk–sharing plan fund, the amounts in the

7 schedule ~~from the health insurance risk–sharing plan fund~~ for the administration

8 of ch. 149, subject to s. 149.143 (2m).".

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

9 **2.** Page 427, line 10: after that line insert:

"**SECTION 415g.** 20.435 (4) (v) of the statutes is created to read:

20.435 **(4)** (v) *Health insurance risk–sharing plan; program benefits.* All moneys received by the health insurance risk–sharing plan fund, except for moneys appropriated under par. (u), for the operating costs of the health insurance risk–sharing plan under ch. 149, subject to s. 149.143 (2m).".

3. Page 427, line 14: delete lines 14 to 15 and substitute:

"**SECTION 417c.** 20.435 (5) (af) of the statutes is renumbered 20.435 (4) (af) and amended to read:

20.435 **(4)** (af) *Health insurance risk–sharing plan; transfer to fund for costs.* The amounts in the schedule to be paid into the health insurance risk–sharing fund for paying a portion of the operating costs of the health insurance risk–sharing plan under ch. 149.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

SECTION 418c. 20.435 (5) (ah) of the statutes is renumbered 20.435 (4) (ah) and amended to read:

20.435 **(4)** (ah) *Health insurance risk–sharing plan; transfer to fund for premium and deductible reduction subsidy.* Biennially, the amounts in the schedule to be paid into the health insurance risk–sharing fund for the purpose of subsidizing premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a).".

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

that line and substitute

Fix component

1 **4.** Page 430, line 5: delete ~~"renumbered 20.435 (4) (gh)" and substitute~~
2 ~~"repealed"~~. "SECTION 433d RP; 20.435 (5)(gh)"

3 **5.** Page 497, line 17: after that line insert:

4 "**SECTION 697r.** 25.17 (1) (gf) of the statutes is created to read:

5 25.17 **(1)** (gf) Health insurance risk–sharing plan fund (s. 25.55);".

6 **6.** Page 501, line 16: after that line insert:

7 "**SECTION 717m.** 25.55 of the statutes is created to read:

8 **25.55 Health insurance risk–sharing plan fund.** There is established a separate

9 nonlapsible trust fund designated as the health insurance risk–sharing plan fund,

10 to consist of:

11 **(1)** All moneys appropriated under s. 20.435 (4) (af).

12 **(2)** All moneys appropriated under s. 20.435 (4) (ah).

13 **(3)** Insurer assessments under ch. 149.

14 **(4)** Premiums paid by eligible persons under ch. 149.".

15 **7.** Page 1052, line 20: after that line insert:

16 **8.** Page 1053, line 12: after that line insert:

17 "**SECTION 2255m.** 149.10 (3e) of the statutes is created to read:

18 149.10 **(3e)** "Fund" means the health insurance risk–sharing plan fund.".

19 "**SECTION 2258d.** 149.125 of the statutes is repealed.

20 **SECTION 2258f.** 149.14 (2) (a) of the statutes is amended to read:

21 149.14 **(2)** (a) The plan shall provide every eligible person who is not eligible

22 for medicare with major medical expense coverage. Major medical expense coverage

23 offered under the plan under this section shall pay an eligible person's covered

24 expenses, subject to sub. (3) and deductible, copayment and coinsurance payments

1 authorized under sub. (5), up to a lifetime limit of $1,000,000 per covered individual.
2 The maximum limit under this paragraph shall not be altered by the board, and no
3 actuarially equivalent benefit may be substituted by the board.".

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

4 **9.** Page 1053, line 16: on lines 16 and 21, delete "~~or~~ 149.144 and 149.15 (3) (e)"
5 and substitute "~~or~~ and 149.144".

6 **10.** Page 1053, line 14: delete the material beginning with that line and
7 ending with page 1054, line 2 and substitute:
8 "SECTION 2259e. 149.14 (3) (intro.) of the statutes is amended to read:
9 149.14 **(3)** COVERED EXPENSES. (intro.) Except as restricted by cost containment
10 provisions under s. 149.17 (4) and except as reduced by the ~~board under s. 149.15 (3)~~
11 ~~(e) or by the~~ department under ~~s.~~ ss. 149.143 ~~or~~ and 149.144, covered expenses for
12 the coverage under this section shall be the ~~usual and customary charges~~ payment
13 rates established by the department under s. 149.142 for the services provided by
14 persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as
15 restricted by cost containment provisions under s. 149.17 (4) and except as reduced
16 by the ~~board under s. 149.15 (3) (e) or by the~~ department under ~~s.~~ ss. 149.143 ~~or~~ and
17 149.144, covered expenses for the coverage under this section shall also be the ~~usual~~
18 ~~and customary charges~~ payment rates established by the department under s.
19 149.142 for the following services and articles if the service or article is prescribed
20 by a physician who is licensed under ch. 448 or in another state and who is certified
21 under s. 49.45 (2) (a) 11. and if the service or article is provided by a provider certified
22 under s. 49.45 (2) (a) 11.:

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

23 SECTION **2259f.** 149.14 (3) (d) of the statutes is amended to read:

(4c)

1 149.14 (3) (d) Drugs requiring a physician's prescription, subject to sub. (4c).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

2 **SECTION 2259r.** 149.14 (4) (d) of the statutes is amended to read:

3 149.14 **(4)** (d) That part of any charge for services or articles rendered or
4 prescribed by a physician, dentist or other health care personnel which exceeds the
5 ~~prevailing charge in the locality where the service is provided~~ payment rate
6 established by the department under s. 149.142 or any charge not medically
7 necessary.".

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

8 **11.** Page 1054, line 4: after that line insert:

9 "**SECTION 2260d.** 149.14 (4c) of the statutes is created to read:

10 149.14 **(4c)** COVERAGE OF PRESCRIPTION DRUGS. The department may require a
11 pharmacist or pharmacy that provides a prescription drug to an eligible person to
12 submit a payment claim directly to the plan administrator. The department may
13 limit coverage of prescription drugs under sub. (3) (d) to those prescription drugs for
14 which payment claims are submitted by pharmacists or pharmacies directly to the
15 plan administrator.

16 **SECTION 2260h.** 149.14 (4m) of the statutes is amended to read:

17 149.14 **(4m)** PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance
18 or deductibles required or authorized under the plan, a provider of a covered service
19 or article shall accept as payment in full for the covered service or article the payment
20 rate determined under ss. 149.142, 149.143~~,~~ and 149.144 ~~and 149.15 (3) (e)~~ and may
21 not bill an eligible person who receives the service or article for any amount by which

1 the charge for the service or article is reduced under s. 149.142, 149.143, or 149.144
2 or 149.15 (3) (e).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

3 **SECTION 2260m.** 149.14 (5) (title) of the statutes is amended to read:

4 149.14 **(5)** (title) DEDUCTIBLES, COPAYMENTS AND COINSURANCE.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

5 **SECTION 2260p.** 149.14 (5) (e) of the statutes is created to read:

6 149.14 **(5)** (e) Subject to sub. (8) (c), the department may establish copayments
7 for prescription drug coverage under sub. (3) (d). Any copayment amounts or rates
8 established are subject to the approval of the board. Copayments paid by an eligible
9 person under this paragraph shall count toward the deductible and covered costs not
10 paid by the plan under pars. (a) to (c).".

11 **12.** Page 1054, line 7: delete the material beginning with that line and ending
12 with page 1056, line 9 and substitute:

13 "**SECTION 2261f.** 149.14 (8) of the statutes is created to read:

14 149.14 **(8)** APPLICABILITY OF MEDICAL ASSISTANCE PROVISIONS. (a) The department
15 may apply to the plan's coverage of services and procedures related to impotence and
16 infertility the same service and coverage policies that apply to coverage of services
17 and procedures related to impotence and infertility under medical assistance under
18 subch. IV of ch. 49.

19 (b) Except as provided in par. (c), the department may apply to the plan the
20 same utilization and cost control procedures that apply under rules promulgated by
21 the department to medical assistance under subch. IV of ch. 49.

1 (c) The department may not apply to eligible persons for covered services or
2 articles the copayments that apply to recipients of medical assistance under subch.
3 IV of ch. 49 for services or articles covered under that program.

4 **SECTION 2261j.** 149.142 of the statutes is created to read:

5 **149.142 Provider payment rates. (1)** (a) Except as provided in par. (b), the
6 department shall establish payment rates for covered expenses that consist of the
7 allowable charges paid under s. 49.46 (2) for the services and articles provided plus
8 an enhancement determined by the department. The rates shall be based on the
9 allowable charges paid under s. 49.46 (2), projected plan costs and trend factors.
10 Using the same methodology that applies to medical assistance under subch. IV of
11 ch. 49, the department shall establish outpatient per visit reimbursement rates and
12 inpatient reimbursement rates that are specific to diagnostically related groups of
13 eligible persons.

14 (b) The payment rate for a prescription drug shall be the allowable charge paid
15 under s. 49.46 (2) (b) 6. h. for the prescription drug.

16 **(2)** The rates established under this section may be reduced under ss. 149.143
17 and 149.144.

18 **SECTION 2261m.** 149.143 (1) (intro.) of the statutes is amended to read:

19 149.143 **(1)** (intro.) The department shall pay or recover the operating costs of
20 the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of
21 the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining
22 the necessary premiums, insurer assessments and provider payment rate
23 adjustments, the department shall apportion and prioritize the responsibility for

1 payment or recovery of plan costs from among the moneys constituting the fund as
2 follows:

History: 1997 a. 27.

3 **SECTION 2262b.** 149.143 (1) (a) of the statutes is amended to read:

4 149.143 **(1)** (a) First from the moneys transferred to the fund from the
5 appropriation account under s. 20.435 ~~(5)~~ (4) (af).

History: 1997 a. 27.

6 **SECTION 2263b.** 149.143 (1) (b) 1. a. of the statutes is amended to read:

7 149.143 **(1)** (b) 1. a. First, from premiums from eligible persons with coverage
8 under s. 149.14 set at 150% of the rate that a standard risk would be charged under
9 an individual policy providing substantially the same coverage and deductibles as
10 are provided under the plan, including amounts received for premium and deductible
11 subsidies under s. 149.144 and under the transfer to the fund from the appropriation
12 account under ~~ss.~~ s. 20.435 ~~(5)~~ (4) (ah) ~~and 149.144~~, and from premiums collected
13 from eligible persons with coverage under s. 149.146 set in accordance with s.
14 149.146 (2) (b).

History: 1997 a. 27.

15 **SECTION 2264b.** 149.143 (1) (b) 1. b. of the statutes is amended to read:

16 149.143 **(1)** (b) 1. b. Second, from ~~the appropriation under s. 20.435 (5) (gh)~~
17 moneys specified under sub. (2m), to the extent that the amounts under subd. 1. a.
18 are insufficient to pay 60% of plan costs.

History: 1997 a. 27.

19 **SECTION 2265b.** 149.143 (1) (b) 1. c. of the statutes is amended to read:

20 149.143 **(1)** (b) 1. c. Third, by increasing premiums from eligible persons with
21 coverage under s. 149.14 to more than 150% but not more than 200% of the rate that
22 a standard risk would be charged under an individual policy providing substantially
23 the same coverage and deductibles as are provided under the plan, including

1 amounts received for premium and deductible subsidies under s. 149.144 and under
2 the transfer to the fund from the appropriation account under ~~ss.~~ s. 20.435 ~~(5)~~ (4) (ah)
3 ~~and 149.144~~, and by increasing premiums from eligible persons with coverage under
4 s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under
5 subd. 1. a. and b. are insufficient to pay 60% of plan costs.

History: 1997 a. 27.

6 **SECTION 2263.** 149.143 (1) (b) 1. d. of the statutes is amended to read:

7 149.143 **(1)** (b) 1. d. Fourth, notwithstanding subd. 2., by increasing insurer
8 assessments, excluding assessments under s. 149.144, and adjusting provider
9 payment rates, excluding adjustments to those rates under ~~ss.~~ s. 149.144 ~~and 149.15~~
10 ~~(3) (e)~~, in equal proportions and to the extent that the amounts under subd. 1. a. to
11 c. are insufficient to pay 60% of plan costs.

History: 1997 a. 27.

12 **SECTION 2264.** 149.143 (1) (b) 2. b. of the statutes is amended to read:

13 149.143 **(1)** (b) 2. b. Fifty percent from adjustments to provider payment rates,
14 excluding adjustments to those rates under ~~ss.~~ s. 149.144 ~~and 149.15 (3) (e)~~.

History: 1997 a. 27.

15 **SECTION 2265.** 149.143 (2) (a) 1. a. of the statutes is amended to read:

16 149.143 **(2)** (a) 1. a. Estimate the amount of enrollee premiums that would be
17 received in the new plan year if the enrollee premiums were set at a level sufficient,
18 when including amounts received for premium and deductible subsidies under s.
19 149.144 and under the transfer to the fund from the appropriation account under ~~ss.~~
20 s. 20.435 ~~(5)~~ (4) (ah) ~~and 149.144~~ and from premiums collected from eligible persons
21 with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60%
22 of the estimated plan costs for the new plan year, after deducting from the estimated

1 plan costs the amount available ~~in~~ to be transferred to the fund from the
2 appropriation account under s. 20.435 ~~(5)~~ (4) (af) for that plan year.

History: 1997 a. 27.

3 **SECTION 2267b.** 149.143 (2) (a) 1. c. of the statutes is repealed.
4 **SECTION 2267g.** 149.143 (2m) of the statutes is created to read:
5 149.143 **(2m)** (a) The department shall keep a separate accounting of the
6 difference between the following:
7 1. The amount of premiums received in a plan year from all eligible persons,
8 including amounts received for premium and deductible subsidies.
9 2. The amount of premiums, including amounts received for premium and
10 deductible subsidies, necessary to cover 60% of the plan costs for the plan year, after
11 deducting the amount transferred to the fund from the appropriation account under
12 s. 20.435 (4) (af).
13 (b) Any amount by which the amount under par. (a) 1. exceeds the amount
14 under par. (a) 2. may be used only as follows:
15 1. To reduce premiums in succeeding plan years as provided in sub. (1) (b) 1.
16 b. ~~but not~~ below 150% of the rate that a standard risk would be charged under an
17 individual policy providing substantially the same coverage and deductibles as are
18 provided under the plan ~~for eligible persons with coverage under s. 149.14.~~
19 2. For other needs of eligible persons, with the approval of the board.
20 **SECTION 2267j.** 149.143 (3) (b) of the statutes is amended to read:
21 149.143 **(3)** (b) If~~, after increasing~~ the department increases premium rates
22 and insurer assessments and ~~adjusting~~ adjusts the provider payment rate under par.
23 (a)~~, the department~~ and determines that there will still be a deficit and that premium
24 rates have been increased to the maximum extent allowable under par. (a), the

1 department ~~shall~~ may further adjust, in equal proportions, assessments set under
2 sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard
3 to sub. (1) (b) 2.

History: 1997 a. 27.

4 **SECTION 2267m.** 149.143 (5) of the statutes is created to read:

5 149.143 **(5)** (a) Annually, no later than April 30, the department shall perform
6 a reconciliation with respect to plan costs, premiums, insurer assessments and
7 provider payment rate adjustments based on data from the previous calendar year.
8 On the basis of the reconciliation, the department shall make any necessary
9 adjustments in premiums, insurer assessments or provider payment rates for the
10 fiscal year beginning on the first July 1 after the reconciliation, as provided in sub.
11 (2) (b).

12 (b) Notwithstanding sub. (3) and s. 149.144, the department shall adjust
13 the provider payment rates to meet the providers' specified portion of the plan costs
14 no more than once annually. The department may not determine the adjustment on
15 an individual provider basis or on the basis of provider type, but shall determine the
16 adjustment for all providers in the aggregate.

17 **SECTION 2267r.** 149.144 of the statutes is amended to read:

18 **149.144 Adjustments to insurer assessments and provider payment**
19 **rates for premium and deductible reductions.** If the moneys transferred to the
20 fund under the appropriation under s. 20.435 ~~(5)~~ (4) (ah) are insufficient to reimburse
21 the plan for premium reductions under s. 149.165 and deductible reductions under
22 s. 149.14 (5) (a), or the department determines that the moneys transferred or to be
23 transferred to the fund under the appropriation under s. 20.435 ~~(5)~~ (4) (ah) will be
24 insufficient to reimburse the plan for premium reductions under s. 149.165 and

1 deductible reductions under s. 149.14 (5) (a), the department shall, by rule, adjust
2 in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and
3 the provider payment rate set under s. 149.143 (2) (a) 4., subject to s. 149.143 (1) (b)
4 1., sufficient to reimburse the plan for premium reductions under s. 149.165 and
5 deductible reductions under s. 149.14 (5) (a). The department shall notify the
6 commissioner so that the commissioner may levy any increase in insurer
7 assessments.

History: 1997 a. 27 ss. 4840c, 4845c.

8 SECTION 2268m. 149.145 of the statutes is amended to read:
9 **149.145 Program budget.** The department, in consultation with the board,
10 shall establish a program budget for each plan year. The program budget shall be
11 based on the provider payment rates specified in s. ~~149.15 (3) (e)~~ 149.142 and in the
12 most recent provider contracts that are in effect and on the funding sources specified
13 in s. 149.143 (1), including the methodologies specified in ss. 149.143, 149.144 and
14 149.146 for determining premium rates, insurer assessments and provider payment
15 rates. Except as otherwise provided in s. 149.143 (3) (a) and (b), from the program
16 budget the department shall derive the actual provider payment rate for a plan year
17 that reflects the providers' proportional share of the plan costs, consistent with ss.
18 149.143 and 149.144. The department may not implement a program budget
19 established under this section unless it is approved by the board.".

History: 1997 a. 27.

20 **13.** Page 1057, line 19: delete the material beginning with that line and
21 ending with page 1058, line ~~19~~ 23, and substitute:
22 "SECTION 2276m. 149.15 (3) (e) of the statutes is repealed.
23 SECTION 2277c. 149.15 (3) (g) of the statutes is created to read:

1 149.15 **(3)** (g) Establish oversight committees to address various
2 administrative issues, such as financial management of the plan and plan
3 administrator performance standards. A representative of the department may not
4 be the chairperson of any committee established under this paragraph.

5 SECTION 2277f. 149.16 (4) of the statutes is created to read:

6 149.16 **(4)** The department shall obtain the approval of the board before
7 implementing any contract with the plan administrator.".

8 ~~14. Page 1058, line 21: delete lines 21 to 23 and substitute:~~

SECTION 2278b. AM. 149.165 (4)

9 "149.165 **(4)** The department shall reimburse the plan for premium reductions
10 under sub. (2) and deductible reductions under s. 149.14 (5) (a) with moneys
11 transferred to the fund from the appropriation account under s. 20.435 ~~(5)~~ (4) (ah).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165.

12 SECTION 2278c. 149.17 (2) of the statutes is amended to read:

13 149.17 **(2)** A schedule of premiums, deductibles, copayments and coinsurance
14 payments ~~which~~ that complies with all requirements of this chapter.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17.

15 SECTION 2278g. 149.17 (4) of the statutes is amended to read:

16 149.17 **(4)** Cost containment provisions established by the department by rule,
17 including managed care requirements. The department shall obtain the approval of
18 the board before promulgating a rule that establishes a cost containment provision
19 that would have an effect on an eligible person's access to health care services, such
20 as the creation of new prior authorization requirements.".

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17.

21 **(END)**

D-note

LRBb0577/1dn
PJK:...:...:....
jlg

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

Amie:

1. Payment for health care services, for purposes of what the plan will pay (covered costs), are clearly reduced under ss. 149.14 (3) and (4m), 149.142, 149.143 and 149.144. Do we need to worry about whether what covered persons must pay (deductibles, copayments and coinsurance) will also be reduced?

2. Should s. 149.143 (3m) specifically be limited to any deficit incurred under sub. (3), even though the provision is explicitly subject to s. 149.14 (4m)?

3. I assumed in s. 149.143 (2m) (b) 1. that the 150% limitation applied only to premiums for persons with coverage under s. 149.14 (not s. 149.146). Okay?

4. I'm not sure that I translated the language for s. 149.143 (5) (b) correctly. Please review.

5. We can still add treatment for impotence or infertility under s. 149.14 (3) or (4) if DHFS gets back to you on that.

6. Especially because of s. 149.143 (5) (b), it might be a good idea to simply get rid of s. 149.143 (3). Also, if any plan deficit will be made up in the following plan year by increasing assessments and reducing provider rates, maybe s. 149.143 (3m) does not really make sense anymore. What do you think? (I'm quite uncomfortable with the interactions among ss. 149.142, 149.143, 149.144 and 149.145.)

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: Pam.Kahler@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb0577/1dn
PJK:jlg:km

June 11, 1999

Amie:

1. Payment for health care services, for purposes of what the plan will pay (covered costs), are clearly reduced under ss. 149.14 (3) and (4m), 149.142, 149.143 and 149.144. Do we need to worry about whether what covered persons must pay (deductibles, copayments and coinsurance) will also be reduced?

2. Should s. 149.143 (3m) specifically be limited to any deficit incurred under sub. (3), even though the provision is explicitly subject to s. 149.14 (4m)?

3. I assumed in s. 149.143 (2m) (b) 1. that the 150% limitation applied only to premiums for persons with coverage under s. 149.14 (not s. 149.146). Okay?

4. I'm not sure that I translated the language for s. 149.143 (5) (b) correctly. Please review.

5. We can still add treatment for impotence or infertility under s. 149.14 (3) or (4) if DHFS gets back to you on that.

6. Especially because of s. 149.143 (5) (b), it might be a good idea to simply get rid of s. 149.143 (3). Also, if any plan deficit will be made up in the following plan year by increasing assessments and reducing provider rates, maybe s. 149.143 (3m) does not really make sense anymore. What do you think? (I'm quite uncomfortable with the interactions among ss. 149.142, 149.143, 149.144 and 149.145.)

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: Pam.Kahler@legis.state.wi.us

State of Wisconsin
1999 – 2000 LEGISLATURE

LRBb0577/1
PJK:lg:km

LFB:......Goldman – Modifications to HIRSP

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

LFB AMENDMENT

TO 1999 ASSEMBLY BILL 133 AND 1999 SENATE BILL 45

At the locations indicated, amend the bill as follows:

1. Page 420, line 20: delete that line and substitute:

"SECTION **386b.** 20.435 (1) (u) of the statutes is renumbered 20.435 (4) (u) and amended to read:

20.435 **(4)** (u) *Health insurance risk–sharing plan; administration.* ~~The~~ Biennially, from the health insurance risk–sharing plan fund, the amounts in the schedule ~~from the health insurance risk–sharing plan fund~~ for the administration of ch. 149, subject to s. 149.143 (2m).".

2. Page 427, line 10: after that line insert:

"SECTION **415g.** 20.435 (4) (v) of the statutes is created to read:

1 20.435 **(4)** (v) *Health insurance risk–sharing plan; program benefits.* All
2 moneys received by the health insurance risk–sharing plan fund, except for moneys
3 appropriated under par. (u), for the operating costs of the health insurance
4 risk–sharing plan under ch. 149, subject to s. 149.143 (2m).".

5 **3.** Page 427, line 14: delete lines 14 and 15 and substitute:

6 "**SECTION 417c.** 20.435 (5) (af) of the statutes is renumbered 20.435 (4) (af) and
7 amended to read:

8 20.435 **(4)** (af) *Health insurance risk–sharing plan; transfer to fund for costs.*
9 The amounts in the schedule to be paid into the health insurance risk–sharing plan
10 fund for paying a portion of the operating costs of the health insurance risk–sharing
11 plan under ch. 149.

12 **SECTION 418c.** 20.435 (5) (ah) of the statutes is renumbered 20.435 (4) (ah) and
13 amended to read:

14 20.435 **(4)** (ah) *Health insurance risk–sharing plan; transfer to fund for*
15 *premium and deductible reduction subsidy.* Biennially, the amounts in the schedule
16 to be paid into the health insurance risk–sharing plan fund for the purpose of
17 subsidizing premium reductions under s. 149.165 and deductible reductions under
18 s. 149.14 (5) (a).".

19 **4.** Page 430, line 5: delete that line and substitute:

20 "**SECTION 433d.** 20.435 (5) (gh) of the statutes is repealed.".

21 **5.** Page 497, line 17: after that line insert:

22 "**SECTION 697r.** 25.17 (1) (gf) of the statutes is created to read:

23 25.17 **(1)** (gf) Health insurance risk–sharing plan fund (s. 25.55);".

24 **6.** Page 501, line 16: after that line insert:

1 "SECTION 717m. 25.55 of the statutes is created to read:

2 **25.55 Health insurance risk–sharing plan fund.** There is established a
3 separate nonlapsible trust fund designated as the health insurance risk–sharing
4 plan fund, to consist of:

5 **(1)** All moneys appropriated under s. 20.435 (4) (af).

6 **(2)** All moneys appropriated under s. 20.435 (4) (ah).

7 **(3)** Insurer assessments under ch. 149.

8 **(4)** Premiums paid by eligible persons under ch. 149.".

9 **7.** Page 1052, line 20: after that line insert:

10 "SECTION 2255m. 149.10 (3e) of the statutes is created to read:

11 149.10 **(3e)** "Fund" means the health insurance risk–sharing plan fund.".

12 **8.** Page 1053, line 12: after that line insert:

13 "SECTION 2258d. 149.125 of the statutes is repealed.

14 SECTION 2258f. 149.14 (2) (a) of the statutes is amended to read:

15 149.14 **(2)** (a) The plan shall provide every eligible person who is not eligible
16 for medicare with major medical expense coverage. Major medical expense coverage
17 offered under the plan under this section shall pay an eligible person's covered
18 expenses, subject to sub. (3) and deductible, copayment and coinsurance payments
19 authorized under sub. (5), up to a lifetime limit of $1,000,000 per covered individual.
20 The maximum limit under this paragraph shall not be altered by the board, and no
21 actuarially equivalent benefit may be substituted by the board.".

22 **9.** Page 1053, line 14: delete the material beginning with that line and ending
23 with page 1054, line 2, and substitute:

provided in sub. (4), except as

1 "149.14 **(3)** COVERED EXPENSES. (intro.) Except as restricted by cost
2 containment provisions under s. 149.17 (4) and except as reduced by the ~~board under~~
3 ~~s. 149.15 (3) (e) or by the~~ department under ~~s.~~ ss. 149.143 ~~or~~ and 149.144, covered
4 expenses for the coverage under this section shall be the ~~usual and customary~~
5 ~~charges~~ payment rates established by the department under s. 149.142 for the
6 services provided by persons licensed under ch. 446 and certified under s. 49.45 (2)
7 (a) 11. Except as restricted by cost containment provisions under s. 149.17 (4) and
8 except as reduced by the ~~board under s. 149.15 (3) (e) or by the~~ department under ~~s.~~
9 ss. 149.143 ~~or~~ and 149.144, covered expenses for the coverage under this section shall
10 also be the ~~usual and customary charges~~ payment rates established by the
11 department under s. 149.142 for the following services and articles if the service or
12 article is prescribed by a physician who is licensed under ch. 448 or in another state
13 and who is certified under s. 49.45 (2) (a) 11. and if the service or article is provided
14 by a provider certified under s. 49.45 (2) (a) 11.:

15 **SECTION 2259f.** 149.14 (3) (d) of the statutes is amended to read:

16 149.14 **(3)** (d) Drugs requiring a physician's prescription, subject to sub. (4c).

17 **SECTION 2259r.** 149.14 (4) (d) of the statutes is amended to read:

18 149.14 **(4)** (d) That part of any charge for services or articles rendered or
19 prescribed by a physician, dentist or other health care personnel ~~which~~ that exceeds the
20 ~~prevailing charge in the locality where the service is provided~~ payment rate
21 established by the department under s. 149.142 or any charge not medically
22 necessary.".

and reduced under ss. 149.143 and 149.144

23 **10.** Page 1054, line 4: after that line insert:

24 "SECTION 2260d. 149.14 (4c) of the statutes is created to read:

Insert 4-23

149.14 **(4c)** COVERAGE OF PRESCRIPTION DRUGS. The department may require a pharmacist or pharmacy that provides a prescription drug to an eligible person to submit a payment claim directly to the plan administrator. The department may limit coverage of prescription drugs under sub. (3) (d) to those prescription drugs for which payment claims are submitted by pharmacists or pharmacies directly to the plan administrator.

SECTION 2260h. 149.14 (4m) of the statutes is amended to read:

149.14 **(4m)** PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance or deductibles required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under ss. 149.142, 149.143~~,~~ and 149.144 ~~and 149.15 (3) (e)~~ and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under s. 149.142, 149.143~~,~~ or 149.144 ~~or 149.15 (3) (e)~~.

SECTION 2260m. 149.14 (5) (title) of the statutes is amended to read:

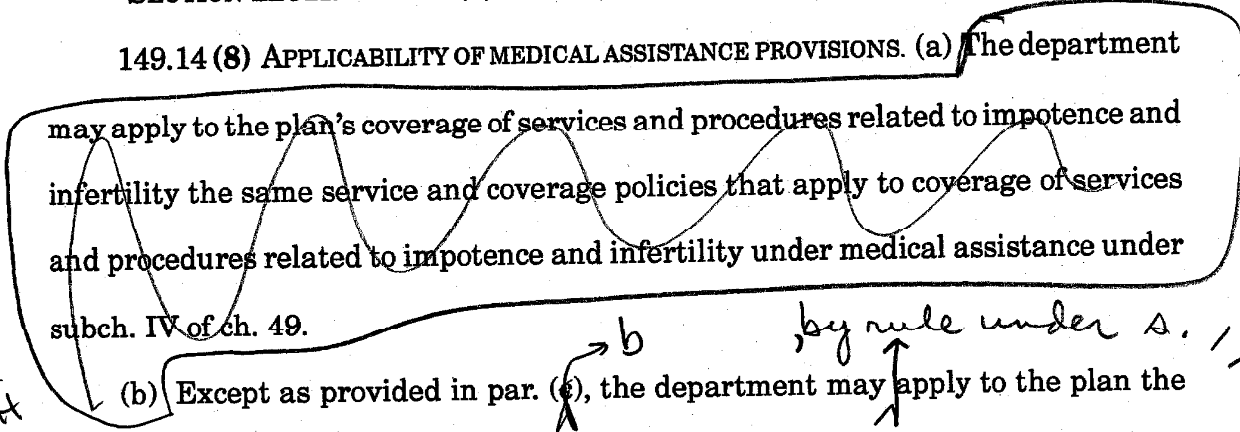
149.14 **(5)** (title) DEDUCTIBLES, COPAYMENTS AND COINSURANCE.

SECTION 2260p. 149.14 (5) (e) of the statutes is created to read:

149.14 **(5)** (e) Subject to sub. (8) (f), the department may establish copayments for prescription drug coverage under sub. (3) (d). Any copayment amounts or rates established are subject to the approval of the board. Copayments paid by an eligible person under this paragraph shall count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).".

11. Page 1054, line 7: delete the material beginning with that line and ending with page 1056, line 9, and substitute:

"**SECTION 2261f.** 149.14 (8) of the statutes is created to read:



149.14 **(8)** APPLICABILITY OF MEDICAL ASSISTANCE PROVISIONS. (a) The department may apply to the plan's coverage of services and procedures related to impotence and infertility the same service and coverage policies that apply to coverage of services and procedures related to impotence and infertility under medical assistance under subch. IV of ch. 49.

(b) Except as provided in par. (c), the department may apply to the plan the same utilization and cost control procedures that apply under rules promulgated by the department to medical assistance under subch. IV of ch. 49.

(c) The department may not apply to eligible persons for covered services or articles the same copayments that apply to recipients of medical assistance under subch. IV of ch. 49 for services or articles covered under that program.

SECTION 2261j. 149.142 of the statutes is created to read:

149.142 Provider payment rates. (1) (a) Except as provided in par. (b), the department shall establish payment rates for covered expenses that consist of the allowable charges paid under s. 49.46 (2) for the services and articles provided plus an enhancement determined by the department. The rates shall be based on the allowable charges paid under s. 49.46 (2), projected plan costs and trend factors. Using the same methodology that applies to medical assistance under subch. IV of ch. 49, the department shall establish outpatient per visit reimbursement rates and inpatient reimbursement rates that are specific to diagnostically related groups of eligible persons.

(b) The payment rate for a prescription drug shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug.

(2) The rates established under this section are subject to adjustment under ss. 149.143 and 149.144.

SECTION 2261m. 149.143 (1) (intro.) of the statutes is amended to read:

149.143 **(1)** (intro.) The department shall pay or recover the operating costs of the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining premiums, insurer assessments and provider payment rate adjustments, the department shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

SECTION 2262b. 149.143 (1) (a) of the statutes is amended to read:

149.143 **(1)** (a) First from the moneys transferred to the fund from the appropriation account under s. 20.435 ~~(5)~~ (4) (af).

SECTION 2263b. 149.143 (1) (b) 1. a. of the statutes is amended to read:

149.143 **(1)** (b) 1. a. First, from premiums from eligible persons with coverage under s. 149.14 set at 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan, including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under ~~ss.~~ s. 20.435 ~~(5)~~ (4) (ah) ~~and 149.144~~, and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

SECTION 2263bm. 149.143 (1) (b) 1. b. of the statutes is amended to read:

149.143 **(1)** (b) 1. b. Second, from ~~the appropriation under s. 20.435 (5) (gh)~~ moneys specified under sub. (2m), to the extent that the amounts under subd. 1. a. are insufficient to pay 60% of plan costs.

SECTION 2263bn. 149.143 (1) (b) 1. c. of the statutes is amended to read:

149.143 **(1)** (b) 1. c. Third, by increasing premiums from eligible persons with coverage under s. 149.14 to more than 150% but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan, including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under ~~ss.~~ s. 20.435 ~~(5)~~ (4) (ah) ~~and 149.144~~, and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay 60% of plan costs.

SECTION 2263bp. 149.143 (1) (b) 1. d. of the statutes is amended to read:

149.143 **(1)** (b) 1. d. Fourth, notwithstanding subd. 2., by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, excluding adjustments to those rates under ~~ss.~~ s. 149.144 ~~and 149.15 (3) (e)~~, in equal proportions and to the extent that the amounts under subd. 1. a. to c. are insufficient to pay 60% of plan costs.

SECTION 2264e. 149.143 (1) (b) 2. b. of the statutes is amended to read:

149.143 **(1)** (b) 2. b. Fifty percent from adjustments to provider payment rates, excluding adjustments to those rates under ~~ss.~~ s. 149.144 ~~and 149.15 (3) (e)~~.

SECTION 2265b. 149.143 (2) (a) 1. a. of the statutes is amended to read:

149.143 **(2)** (a) 1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under ~~ss.~~ s. 20.435 ~~(5)~~ (4) (ah) ~~and 149.144~~ and from premiums collected from eligible persons

with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60% of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available ~~in~~ for transfer to the fund from the appropriation account under s. 20.435 ~~(5)~~ (4) (af) for that plan year.

SECTION 2265bm. 149.143 (2) (a) 1. c. of the statutes is repealed.

SECTION 2266g. 149.143 (2m) of the statutes is created to read:

149.143 **(2m)** (a) The department shall keep a separate accounting of the difference between the following:

1. The amount of premiums received in a plan year from all eligible persons, including amounts received for premium and deductible subsidies.

2. The amount of premiums, including amounts received for premium and deductible subsidies, necessary to cover 60% of the plan costs for the plan year, after deducting the amount transferred to the fund from the appropriation account under s. 20.435 (4) (af).

(b) Any amount by which the amount under par. (a) 1. exceeds the amount under par. (a) 2. may be used only as follows:

1. To reduce premiums in succeeding plan years as provided in sub. (1) (b) 1. b. For eligible persons with coverage under s. 149.14, premiums may not be reduced below 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

2. For other needs of eligible persons, with the approval of the board.

SECTION 2267j. 149.143 (3) (b) of the statutes is amended to read:

149.143 **(3)** (b) If~~, after increasing~~ the department increases premium rates and insurer assessments and ~~adjusting~~ adjusts the provider payment rate under par.

(a)~~, the department~~ and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department ~~shall~~ may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (b) 2.

SECTION 2267m. 149.143 (5) of the statutes is created to read:

149.143 **(5)** (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments or provider payment rates for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

(b) ~~Notwithstanding~~ Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually. The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate.

SECTION 2267r. 149.144 of the statutes is amended to read:

149.144 Adjustments to insurer assessments and provider payment rates for premium and deductible reductions. If the moneys transferred to the fund under the appropriation under s. 20.435 ~~(5)~~ (4) (ah) are insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), or the department determines that the moneys transferred or to be transferred to the fund under the appropriation under s. 20.435 ~~(5)~~ (4) (ah) will be

1 insufficient to reimburse the plan for premium reductions under s. 149.165 and
2 deductible reductions under s. 149.14 (5) (a), the department ~~shall~~, by rule, adjust
3 in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and
4 the provider payment rate set under s. 149.143 (2) (a) 4., subject to s. 149.143 (1) (b)
5 1., sufficient to reimburse the plan for premium reductions under s. 149.165 and
6 deductible reductions under s. 149.14 (5) (a). ~~The~~ department shall notify the
7 commissioner so that the commissioner may levy any increase in insurer
8 assessments.

9 **SECTION 2268m.** 149.145 of the statutes is amended to read:

10 **149.145 Program budget.** The department, in consultation with the board,
11 shall establish a program budget for each plan year. The program budget shall be
12 based on the provider payment rates specified in s. ~~149.15 (3) (e)~~ 149.142 and in the
13 most recent provider contracts that are in effect and on the funding sources specified
14 in s. 149.143 (1), including the methodologies specified in ss. 149.143, 149.144 and
15 149.146 for determining premium rates, insurer assessments and provider payment
16 rates. Except as otherwise provided in s. 149.143 (3) (a) and (b), from the program
17 budget the department shall derive the actual provider payment rate for a plan year
18 that reflects the providers' proportional share of the plan costs, consistent with ss.
19 149.143 and 149.144. The department may not implement a program budget
20 established under this section unless it is approved by the board.".

21 **12.** Page 1057, line 19: delete the material beginning with that line and
22 ending with page 1058, line 23, and substitute:

23 "**SECTION 2276m.** 149.15 (3) (e) of the statutes is repealed.

24 **SECTION 2277c.** 149.15 (3) (g) of the statutes is created to read:

may

If the department makes the adjustment under this section, the

1 149.15 **(3)** (g) Establish oversight committees to address various
2 administrative issues, such as financial management of the plan and plan
3 administrator performance standards. A representative of the department may not
4 be the chairperson of any committee established under this paragraph.

5 **SECTION 2277f.** 149.16 (4) of the statutes is created to read:

6 149.16 **(4)** The department shall obtain the approval of the board before
7 implementing any contract with the plan administrator.

8 **SECTION 2278b.** 149.165 (4) of the statutes is amended to read:

9 149.165 **(4)** The department shall reimburse the plan for premium reductions
10 under sub. (2) and deductible reductions under s. 149.14 (5) (a) with moneys
11 transferred to the fund from the appropriation account under s. 20.435 ~~(5)~~ (4) (ah).

12 **SECTION 2278c.** 149.17 (2) of the statutes is amended to read:

13 149.17 **(2)** A schedule of premiums, deductibles, copayments and coinsurance
14 payments ~~which~~ that complies with all requirements of this chapter.

15 **SECTION 2278g.** 149.17 (4) of the statutes is amended to read:

16 149.17 **(4)** Cost containment provisions established by the department by rule,
17 including managed care requirements. The department shall obtain the approval of
18 the board before promulgating a rule that establishes a cost containment provision
19 that would have an effect on an eligible person's access to health care services, such
20 as the creation of new prior authorization requirements.".

21 **(END)**

Insert 12-20

D-note

Insert 4-23 ✓

¶ " SECTION 2260c. CR; 149.14 (4)(n)

¶ 149.14 (4)(n) (B) Services or drugs for the treatment of infertility.

(end of ins. 4-23)

Insert 12-20

#. Page 1473, line 10: after that line insert:

effective dates

"(9z) Health insurance risk-sharing plan. The treatment of sections 20.435 (1) (u), (4) (v) and (5) (af), (ah) and (gh), 25.17 (1) (gf), 25.55, 149.10 (3e), 149.125, 149.14 (2) (a), (3) (intro.) and (d), (4) (d) and (n), (4c), (4m), (5) (title) and (e) and (8), 149.142, 149.143 (1) (intro.), (a) and (b) 1. a., b., c. and d. and 2. b., (2) (a) 1. a. and c., (2m), (3) (b) and (5), 149.144, 149.145, 149.165 (4) and 149.17 (2) of the statutes takes effect on January 1, 2000.".

(end of ins 12-20)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb0577/2dn
PJK:jlg:km

5+ays

Amie:

1. This redraft:

    a. Adds a delayed effective date for all provisions except the treatments of ss. 149.15 (3) (e) and (g), 149.16 (4) and 149.17 (4).

    b. Includes infertility treatment in the exclusions under s. 149.14 (4). I added "except as provided in sub. (4)" to s. 149.14 (3) (intro.) because I wasn't sure which of the covered expenses *could* apply to infertility treatment; drugs, certainly, but the others are not so clear.

    c. Adds "hospital" twice in s. 149.142 (1) (a).

    d. Changes "Notwithstanding" to "Except as provided in" in s. 149.143 (5) (b).

    e. Changes "shall" to "may" in s. 149.144 and, as a result, adds language to the beginning of the last sentence in that section.

    f. Makes a cross–reference to rules under s. 149.17 (4) in s. 149.14 (8) (a).

    g. Adds "and reduced under ss. 149.143 and 149.144" in s. 149.14 (4) (d). We did not discuss this, but it was something that I thought should be added as I was going through the draft.

underscore

2. Do you think that we should specify that copayments for prescription drugs under s. 149.14 (5) (e) must be established by rule under s. 149.17 (4)? Copayments are cost containment measures. On the other hand, since the board must approve the amount of the copayment, it may not be so crucial to specify that they be established by rule.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: Pam.Kahler@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb0577/2dn
PJK:jlg:km

June 12, 1999

Amie:

1. This redraft:

   a. Adds a delayed effective date for all provisions except the treatments of ss. 149.15 (3) (e) and (g), 149.16 (4) and 149.17 (4).

   b. Includes infertility treatment in the exclusions under s. 149.14 (4). I added "except as provided in sub. (4)" to s. 149.14 (3) (intro.) because I wasn't sure which of the covered expenses *could* apply to infertility treatment; drugs, certainly, but the others are not so clear.

   c. Adds "hospital" twice in s. 149.142 (1) (a).

   d. Changes "Notwithstanding" to "Except as provided in" in s. 149.143 (5) (b).

   e. Changes "shall" to "may" in s. 149.144 and, as a result, adds language to the beginning of the last sentence in that section.

   f. Makes a cross–reference to rules under s. 149.17 (4) in s. 149.14 (8) (a).

   g. Adds "<u>and reduced under ss. 149.143 and 149.144</u>" in s. 149.14 (4) (d). We did not discuss this, but it was something that I thought should be added as I was going through the draft.

2. Do you think that we should specify that copayments for prescription drugs under s. 149.14 (5) (e) must be established by rule under s. 149.17 (4)? Copayments are cost containment measures. On the other hand, since the board must approve the amount of the copayment, it may not be so crucial to specify that they be established by rule.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: Pam.Kahler@legis.state.wi.us