2001 ASSEMBLY BILL 876

March 4, 2002 – Introduced by Representatives SERATTI, UNDERHEIM, MONTGOMERY, RHOADES, URBAN, AINSWORTH, BIES, J. FITZGERALD, FRISKE, GRONEMUS, GUNDERSON, HAHN, HUNDERTMARK, JOHNSRUD, KESTELL, KRAWCZYK, LADWIG, LA FAVE, J. LEHMAN, LIPPERT, MCCORMICK, D. MEYER, MUSSER, OLSEN, PETROWSKI, PETTIS, STARZYK, SYKORA, TOWNSEND, VRAKAS and ALBERS, cosponsored by Senators PLACHE, DARLING, HARSDORF and ROESSLER. Referred to Committee on Health.

AN ACT ***to renumber and amend*** 40.51 (6); ***to amend*** 20.145 (1) (g), 20.515 (2) (g), 149.12 (1) (intro.), 149.14 (6) (a) and 632.835 (2) (b); and ***to create*** 15.735, 16.735, 20.145 (1) (j), 20.145 (1) (q), 25.17 (1) (pd), 25.57, 40.51 (6) (b), 40.98 (2) (h), 40.98 (6m), 149.12 (4), 149.14 (6) (c), 601.34, 632.835 (2) (bg), 635.25 and 635.30 of the statutes; **relating to:** a loan from the general fund for the private employer health care coverage program, requiring the group insurance board to offer an additional health insurance plan for state employees, creating a small employer catastrophic reinsurance board, creating a small employer catastrophic care board, creating a small employer catastrophic care program fund, requiring small employer insurers to specify threshold levels of covered benefits and reimbursing small employer insurers that pay benefits in excess of the threshold, imposing an additional premium on small employer insurance to pay reimbursements to small employer insurers, creating a pilot program for reimbursing small employer insurers for claims costs for certain employees of

small employers, authorizing assistance in negotiating prescription drug rebates and reducing prescription drug charges, providing notice of the right to independent review, requiring reports, providing exemptions from emergency rule procedures, granting rule–making authority, and making appropriations.

Analysis by the Legislative Reference Bureau

Private employer health care coverage program

Under current law, the private employer health care coverage board, attached to the department of employee trust funds (DETF), is required to design and oversee a health care coverage program for employers in the private sector. This bill requires that $850,000 in moneys received by the office of the commissioner of insurance for general program operations be used as a loan for the private employer health care coverage program. In addition, the bill authorizes DETF to seek funding from any person for the payment of costs of designing, marketing, and contracting for or providing administrative services under the private employer health care coverage program and for repaying the loan to the office of the commissioner of insurance.

Small employer catastrophic care

This bill creates a catastrophic care program for employees of small employers, which are, generally, employers with two to 50 employees. The program is to operate for five years, and is to be administered by a small employer catastrophic care board (catastrophic care board), which is attached to the office of the commissioner of insurance for administrative purposes. The catastrophic care board is composed of the commissioner of insurance (commissioner) and 10 other members who represent the medical professions, small employers, and small employer insurers, which are insurers that offer group health benefit plans to small employers. The program will operate in a limited region of the state, which must be determined and described by the commissioner by rule, but which must include Winnebago County.

Under the bill, an employee of a small employer is eligible for coverage under the program if: 1) the small employer is located in the region in which the program operates, 2) the employee is eligible for coverage under a group health benefit plan issued or renewed to the small employer, 3) the employee is determined by the small employer insurer issuing or renewing the group health benefit plan to be eligible in accordance with health status underwriting guidelines established by the catastrophic care board, 4) the small employer agrees to enroll the employee in the program, and 5) the small employer pays an additional premium for the employee's coverage under the program. If a small employer does not agree to enroll in the program an employee who is eligible for enrollment, the small employer insurer issuing or renewing the group health benefit plan to the small employer may disregard the rate restrictions in current law for small employer health insurance when determining the premium for the small employer's group health benefit plan.

The covered benefits for an employee enrolled in the program are the same as the benefits under the group health benefit plan for which the employee is eligible. The small employer insurer issuing the group health benefit plan for which the employee is eligible pays or denies payment of the employee's benefit claims. The commissioner, at the direction of the catastrophic care board, reimburses a small employer insurer for benefit claims that are properly paid for employees enrolled in the program. The program is funded by: 1) $500,000 annually from fees imposed under current law by the office of the commissioner of insurance for insurance–related services to pay for regulation of the insurance industry, 2) assessments, which must equal $500,000 annually, that are paid by all insurers authorized to sell health insurance in this state, 3) assessments that are paid by health care professionals, facilities, and organizations and that, in conjunction with health care provider payment rate discounts that the commissioner sets by rule, must equal $500,000 annually, and 4) the additional premiums that must be paid by small employers that agree to enroll under the program employees who are eligible for coverage under the program. The additional premiums, which are determined by the catastrophic care board by rule, must be calculated to cover the anticipated reimbursements to small employer insurers for benefit payments under the program to the extent that the other funding sources will not.

In addition to establishing various procedures for the operation of the program, the catastrophic care board must establish a budget every year, reconcile the program costs with the program funding every year and increase or decrease for the next fiscal year the insurer or provider assessments or provider payment rate discounts if they did not equal the required $500,000 in the previous year, and provide for a program administrator procurement process.

The bill provides that, if an employee who is enrolled in the small employer catastrophic care program loses eligibility, the employee may apply for coverage under the state's health insurance risk–sharing plan (HIRSP), which provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for HIV, and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. The HIRSP board may, in its discretion, certify an employee who loses coverage under the small employer catastrophic care program as eligible for coverage under HIRSP even if the employee does not satisfy HIRSP's eligibility requirements. In addition, if such an employee obtains coverage under HIRSP and his or her application was received within 63 days after his or her coverage under the small employer catastrophic care program was terminated, he or she is not required to satisfy the six–month preexisting condition exclusion period that applies under HIRSP.

Small employer catastrophic reinsurance

This bill creates a catastrophic reinsurance program for small employers, which are, generally, employers with two to 50 employees. The program is to operate for five years, and is to be administered by a small employer catastrophic reinsurance board (reinsurance board), which is attached to the office of the commissioner of insurance for administrative purposes. The reinsurance board is composed of the

commissioner of insurance (commissioner) and eight other members, one of whom is a physician and the rest of whom represent hospitals, small employers, and small employer insurers, which are insurers that offer group health benefit plans to small employers.

Under the program, a small employer insurer must select by December 1 every other year a threshold level of covered benefits, which may be $50,000 per calendar year, $100,000 per calendar year, $150,000 per calendar year, or $250,000 per calendar year. The threshold level selected by a small employer insurer will apply for the next two calendar years to each individual insured under every group health benefit plan issued by the small employer insurer to a small employer. If in a calendar year a small employer insurer pays benefits on behalf of an insured that exceed the threshold level selected by the small employer insurer, the commissioner, at the direction of the reinsurance board, reimburses the small employer insurer for 80% of the benefits payments that exceed the threshold level.

The reimbursements to the small employer insurers are funded by additional premium amounts paid by small employers for coverage under group health benefit plans. The additional premium amount, which is determined by a rule developed by the reinsurance board and promulgated by the commissioner, is based on a charge per covered individual that will generate sufficient funding to cover the small employer insurer reimbursements of 80% of costs over their selected threshold levels. In addition, during the program's operation, providers of health care services to employees covered under group health benefit plans issued to small employers must accept discounts to their payment rates and may not bill employees receiving the services for the difference. The payment rate discounts are set by the commissioner by rule.

State employee health care coverage

Under current law, the state is required to provide health care coverage for eligible state employees. The state must offer state employees at least two insured or uninsured health care coverage plans that provide substantially equivalent hospital and medical benefits. This bill requires the state also to offer state employees a defined contribution plan that permits employees to choose the level of premiums, deductibles, and co–payments and to select the hospital and medical benefits offered under the plan, but only if the group insurance board determines that such a defined contribution plan is available in the area of the place of employment and approves the plan.

Prescription drug rebates and reduced charges

Currently, under the program of prescription drug assistance for elderly persons, moneys from rebate agreements negotiated with prescription drug manufacturers that sell drugs for prescribed use in this state are used to reimburse pharmacies and pharmacists that are required, under the program, to charge eligible persons reduced rates for prescription drugs.

This bill authorizes the department of administration (DOA) or an entity with which DOA contracts, to assist health care providers, insurers, or self–insurers in this state or in conjunction with associations of health care providers, insurers, or self–insurers in states other than Wisconsin to negotiate with manufacturers or

labelers rebate agreements or to develop in–state or multistate purchasing groups to negotiate reduced charges for prescription drugs that are produced by the manufacturers or repackaged by the labelers and sold for prescribed use. Under the bill, DOA must submit a report by January 1, 2003, that identifies: 1) the participation by health care providers, insurers, and self–insurers in negotiating rebate agreements and developing in–state or multistate purchasing groups, and 2) strategies that DOA proposes to pursue to reduce costs for prescription drugs. DOA also must submit a report by January 1, 2005, that specifies the status, including success or lack of success, in assisting health care providers, insurers, or self–insurers to negotiate rebate agreements or reduce charges for prescription drugs. Both reports must be submitted to appropriate standing committees of the legislature, to the joint committee on finance, and to the governor.

Notice of independent review

Under current law, an insured under a health benefit plan has the right to obtain, from an independent review organization certified by the commissioner of insurance, an independent review of certain denials of coverage (adverse determinations and experimental treatment determinations). Whenever an adverse determination or experimental treatment determination is made, the insurer is required to provide notice to the insured of his or her right to obtain an independent review, of how to request the review, and of the time within which the review must be requested and is required to provide a current listing of certified independent review organizations.

This bill provides that an insurer is not required to provide the notice about the independent review procedure to an insured who uses the insurer's internal grievance procedure until the insurer sends notice of the disposition of the internal grievance if the health benefit plan issued by the insurer contains a description of the procedure, including a description of the insured's right to obtain an independent review, how to request the review, the time within which the review must be requested, and how to obtain a current listing of certified independent review organizations. In addition, the insurer must provide on its explanation of benefits form a reference to the section of the policy or certificate that contains the description. (An insurer sends its explanation of benefits form to an insured after the insured has received health care services to provide information about the extent to which the insurance covered the services.)

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 15.735 of the statutes is created to read:

15.735 Same; attached boards. (1) SMALL EMPLOYER CATASTROPHIC REINSURANCE BOARD. (a) There is created a small employer catastrophic reinsurance board that is attached to the office of the commissioner of insurance under s. 15.03. The board shall consist of the commissioner of insurance and the following members:

1. Two members who represent small employers, as defined in s. 635.02 (7), and who are selected from a list of nominees submitted by the National Federation of Independent Business and Wisconsin Independent Businesses, Inc.

2. Four members who represent small employer insurers, as defined in s. 635.02 (8), 2 of whom are selected from a list of nominees submitted by the Wisconsin Association of Life and Health Insurers, Inc., and 2 of whom are selected from a list of nominees submitted by the Wisconsin Association of Health Plans.

3. One member who is a physician, as defined in s. 448.01 (5), and who is selected from a list of nominees submitted by the State Medical Society of Wisconsin.

4. One member who represents hospitals and who is selected from a list of nominees submitted by the Wisconsin Health and Hospital Association.

(b) The members under par. (a) 1. to 4. shall be appointed for 3–year terms. Any such member may be removed by the governor for just cause.

(2) SMALL EMPLOYER CATASTROPHIC CARE BOARD. (a) There is created a small employer catastrophic care board that is attached to the office of the commissioner of insurance under s. 15.03. The board shall consist of the commissioner of insurance and the following members:

1. Four members who are small employers, as defined in s. 635.02 (7).

2. Four members who are small employer insurers, as defined in s. 635.02 (8).

3. Two members who represent the medical professions, at least one of whom is a physician, as defined in s. 448.01 (5).

(b) The members under par. (a) 1. to 3. shall be appointed for 3–year terms. Any such member may be removed by the governor for just cause.

SECTION 2. 16.735 of the statutes is created to read:

16.735 Negotiations for purchase of prescription drugs; rebates. (1) In this section:

(a) "Health care provider" has the meaning given in s. 146.81 (1).

(b) "Insurer" has the meaning given in s. 632.745 (15).

(c) "Labeler" means a person that receives prescription drugs from a manufacturer or wholesaler, repackages the prescription drugs for later retail sale, and has a labeler code issued by the federal food and drug administration under 21 CFR 207.20 (b).

(d) "Manufacturer" means a manufacturer of prescription drugs and includes a subsidiary or affiliate of the manufacturer.

(e) "Pharmacist" has the meaning given in s. 450.01 (15).

(f) "Prescription drug" has the meaning given in s. 450.01 (20).

(g) "Self–insurer" means an employer or labor organization acting solely or acting jointly with a labor organization or an employer to provide employee health care benefits on a self–insured basis.

(2) The department or an entity with which the department contracts may do all of the following:

(a) Assist a health care provider, insurer, or self–insurer that acts in this state or that seeks to act in conjunction with associations of health care providers, insurers, or self–insurers in states other than this state to negotiate rebate agreements with manufacturers or labelers for prescription drugs that are produced by the manufacturers or repackaged by the labelers and are sold for prescribed use.

(b) Assist a health care provider, insurer, or self–insurer to develop an in–state purchasing group or, in conjunction with associations of health care providers, insurers, or self–insurers in states other than this state, a multistate purchasing group, for the direct negotiation with prescription drug manufacturers and labelers of reduced charges for prescription drugs that are produced by the manufacturers or repackaged by the labelers and are sold for prescribed use.

SECTION 3. 20.145 (1) (g) of the statutes, as affected by 2001 Wisconsin Act 16, is amended to read:

20.145 **(1)** (g) *General program operations.* The amounts in the schedule for general program operations and to transfer to the small employer catastrophic care program fund $500,000 annually, by no later than January 30, beginning in 2003 and ending in 2007. Ninety percent of all moneys received under ss. 601.31, 601.32, 601.42 (7), 601.45, and 601.47 and by the commissioner for expenses related to insurance company restructurings, except for restructurings specified in par. (h), shall be credited to this appropriation account.

SECTION 4. 20.145 (1) (j) of the statutes is created to read:

20.145 **(1)** (j) *Small employer insurer catastrophic reimbursements.* All moneys received under s. 635.25 (3) (b), to reimburse small employer insurers as provided in s. 635.25 (2) (c).

SECTION 5. 20.145 (1) (q) of the statutes is created to read:

20.145 **(1)** (q) *Small employer catastrophic care program reimbursements.* From the small employer catastrophic care program fund, a sum sufficient for reimbursing claims costs under s. 635.30 (6) (c).

SECTION 6. 20.515 (2) (g) of the statutes is amended to read:

20.515 **(2)** (g) *Private employer health care coverage plan.* All moneys received under subch. X of ch. 40 from employers who elect to participate in the private employer health care coverage program under subch. X of ch. 40 and from any other person under s. 40.98 (2) (h), for the costs of designing, marketing, and contracting for or providing administrative services for the program and for lapsing to the general fund the amounts required under s. 40.98 (6m).

SECTION 7. 25.17 (1) (pd) of the statutes is created to read:

25.17 **(1)** (pd) Small employer catastrophic care program fund (s. 25.57);

SECTION 8. 25.57 of the statutes is created to read:

25.57 Small employer catastrophic care program fund. There is established a separate nonlapsible trust fund designated as the small employer catastrophic care program fund, to consist of:

(1) The moneys transferred under s. 20.145 (1) (g).

(2) Insurer assessments established under s. 635.30 (3) (a) 2.

(3) Provider assessments established under s. 635.30 (3) (a) 3.

(4) Premiums established under s. 635.30 (3) (a) 4.

SECTION 9. 40.51 (6) of the statutes is renumbered 40.51 (6) (a) and amended to read:

40.51 **(6)** (a) ~~This~~ Except as provided in par. (b), the state shall offer to all of its employees at least 2 insured or uninsured health care coverage plans providing substantially equivalent hospital and medical benefits, including a health maintenance organization or a preferred provider plan, if those health care plans are determined by the group insurance board to be available in the area of the place of employment and are approved by the group insurance board.

SECTION 10. 40.51 (6) (b) of the statutes is created to read:

40.51 **(6)** (b) Notwithstanding s. 40.03 (6) (c), in addition to the health care coverage plans offered under par. (a), the state shall also offer to all of its employees a defined contribution plan that permits employees to choose the level of premiums, deductibles, and co–payments and to select the hospital and medical benefits offered under the plan, but only if the group insurance board determines that such a defined contribution plan is available in the area of the place of employment and approves the plan.

SECTION 11. 40.98 (2) (h) of the statutes is created to read:

40.98 **(2)** (h) The department may seek funding from any person for the payment of costs of designing, marketing, and contracting for or providing administrative services under the health care coverage program and for lapsing to the general fund any amount required under sub. (6m). Any moneys received by the department under this paragraph shall be credited to the appropriation account under s. 20.515 (2) (g).

SECTION 12. 40.98 (6m) of the statutes is created to read:

40.98 **(6m)** The secretary of administration shall lapse from the appropriation under s. 20.515 (2) (g) to the general fund the amounts necessary to repay the loan under s. 601.34 when the secretary of administration, after consulting with the board, determines that funds in the appropriation under s. 20.515 (2) (g) are sufficient to make the lapse. The amounts that are required to be lapsed under s. 20.515 (2) (g) shall equal the amount necessary to pay all principal and interest costs on the loan, less any amount that is lapsed to the general fund under s. 20.515 (2) (a) at the end of the 2001–03 fiscal biennium. The secretary of administration may lapse the amounts under s. 20.515 (2) (g) in installments.

SECTION 13. 149.12 (1) (intro.) of the statutes is amended to read:

149.12 **(1)** (intro.) Except as provided in subs. (1m) ~~and,~~ (2)<u>, and (4)</u>, the board or plan administrator shall certify as eligible a person who is covered by medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has tested positive for the presence of HIV, antigen or nonantigenic products of HIV<u>,</u> or an antibody to HIV, a person who is an eligible individual, and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

SECTION 14. 149.12 (4) of the statutes is created to read:

149.12 **(4)** Notwithstanding subs. (1) to (3), the board may, in its discretion, certify as eligible for coverage under the plan a person who applies for coverage after his or her enrollment in the program under s. 635.30 is terminated under s. 635.30 (4) (b), regardless of whether the person satisfies the eligibility requirements under subs. (1) to (3). The board shall determine whether a person who obtains coverage under the plan under this subsection and who does not satisfy the eligibility requirements under subs. (1) to (3) may remain covered under the plan after the program under s. 635.30 is no longer in operation.

SECTION 15. 149.14 (6) (a) of the statutes is amended to read:

149.14 **(6)** (a) Except as provided in ~~par.~~ <u>pars.</u> (b) <u>and (c)</u>, no person who obtains coverage under the plan may be covered for any preexisting condition during the first 6 months of coverage under the plan if the person was diagnosed or treated for that condition during the 6 months immediately preceding the filing of an application with the plan.

SECTION 16. 149.14 (6) (c) of the statutes is created to read:

149.14 **(6)** (c) A person who obtains coverage under the plan under s. 149.12 (4) and whose application for coverage was received within 63 after his or her enrollment in the program under s. 635.30 was terminated under s. 635.30 (4) (b), may not be subject to any preexisting condition exclusion under the plan, as provided in s. 635.30 (4) (b).

SECTION 17. 601.34 of the statutes is created to read:

601.34 Loan to general fund. No later than the first day of the 2nd month after the effective date of this section .... [revisor inserts date], an amount equal to $850,000 shall be lapsed from the appropriation account under s. 20.145 (1) (g) to the general fund. The amount lapsed from the appropriation account shall be considered a loan to the general fund and interest shall accrue on the amount lapsed at the average rate earned by the state on its deposits in the state investment fund during the period of the loan. The general fund shall repay the loan from moneys lapsed to the general fund from the appropriation under s. 20.515 (2) (a) at the end of the 2001–03 fiscal biennium, if any, and from moneys lapsed to the general fund from the appropriation under s. 20.515 (2) (g) in the amounts specified in s. 40.98 (6m). If the secretary of administration determines that the moneys lapsed from these appropriations will not be sufficient to repay the loan within a reasonable period of time, as determined by the secretary and the commissioner, the secretary shall credit the appropriation account under s. 20.145 (1) (g) from moneys in the general fund an amount sufficient to repay the loan.

SECTION 18. 632.835 (2) (b) of the statutes, as created by 1999 Wisconsin Act 155, is amended to read:

632.835 **(2)** (b) ~~Whenever~~ If an adverse determination or an experimental treatment determination is made, the insurer involved in the determination shall

provide notice to the insured of the insured's right to obtain the independent review required under this section, how to request the review, and the time within which the review must be requested. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the insured.

SECTION 19. 632.835 (2) (bg) of the statutes is created to read:

632.835 **(2)** (bg) Notwithstanding par. (b), an insurer is not required to provide the notice under par. (b) to an insured who uses the internal grievance procedure under s. 632.83 until the insurer sends it notice of the disposition of the internal grievance if all of the following apply:

1. The health benefit plan issued by the insurer contains a description of the independent review procedure under this section, including an explanation of the insured's rights under par. (d), how to request the review, the time within which the review must be requested, and how to obtain a current listing of independent review organizations certified under sub. (4).

2. The insurer includes on its explanation of benefits form a reference to the section of the policy or certificate that contains the description of the independent review procedure.

SECTION 20. 635.25 of the statutes is created to read:

635.25 Catastrophic risk. (1) DEFINITION. In this section, "board" means the small employer catastrophic reinsurance board.

(2) THRESHOLDS FOR COVERED BENEFITS. (a) By December 1, 2002, and every 2 years thereafter until December 1, 2006, every small employer insurer shall select,

and submit a report to the commissioner that specifies, the small employer insurer's threshold level of covered benefits, which may be any of the following:

1. Fifty thousand dollars in a calendar year.

2. One hundred thousand dollars in a calendar year.

3. One hundred fifty thousand dollars in a calendar year.

4. Two hundred fifty thousand dollars in a calendar year.

(b) The threshold level of benefits specified in a report under par. (a) shall apply to each insured under every group health benefit plan issued to a small employer in this state by the small employer insurer submitting the report.

(c) For each of the 2 calendar years after the year in which a small employer insurer submits a report under par. (a), if the amount of covered benefits paid in a calendar year, beginning with 2004 and ending with 2008, by the small employer insurer on behalf of any insured under any group health benefit plan to which this section applies exceeds the threshold level of covered benefits specified in the report, the commissioner, at the direction of the board, shall reimburse the small employer insurer from the appropriation under s. 20.145 (1) (j), in accordance with the procedures established by rule under sub. (5) (e), for 80% of the amount paid by the small employer insurer in that calendar year in excess of the threshold level specified in the report.

(3) PREMIUMS FOR REIMBURSEMENTS. (a) For every group health benefit plan issued or renewed to a small employer in this state on or between the dates specified by rule under sub. (5) (b), a small employer insurer shall charge a total premium that includes the premium amount established by rule under sub. (5) (a).

(b) By the date specified by rule under sub. (5) (c), a small employer insurer shall forward to the board the premiums established by rule under sub. (5) (a), in the

manner required by rule under sub. (5) (d). The board shall credit all premium amounts received under this paragraph to the appropriation account under s. 20.145 (1) (j).

(c) In addition to the disclosures required under s. 635.11, before the issuance or renewal of a group health benefit plan to a small employer in this state on or between the dates specified by rule under sub. (5) (b), a small employer insurer shall disclose to the small employer all of the following:

1. The small employer insurer's current threshold level of covered benefits under sub. (2) (a) and the calendar years to which it applies.

2. The amount of the total premium that is attributable to coverage for the small employer insurer's threshold level of covered benefits and 20% of covered benefits in excess of that threshold level.

3. The amount of the total premium that is the premium amount established by rule under sub. (5) (a).

(4) PROVIDER DISCOUNTS. (a) The commissioner by rule shall establish provider discount rates for charges for covered services provided to insureds under group health benefit plans that are issued or renewed to small employers in this state on or between the dates specified by rule under sub. (5) (b). The commissioner may establish higher provider discount rates for covered benefits under group health benefit plans that are issued by small employer insurers that specify higher threshold levels under sub. (2) (a).

(b) Except for copayments, coinsurance, or deductibles required or authorized under a group health benefit plan, a provider of a covered service, drug, or device shall accept as payment in full for the covered service, drug, or device the discounted payment rate under par. (a) and may not bill the insured under the group health

benefit plan who receives the service, drug, or device for any amount by which the charge is reduced under par. (a).

(5) RULES. The commissioner shall promulgate rules developed by the board for the operation of this section, including rules that do all of the following:

(a) Establish and periodically adjust the premium amounts that must be charged to small employers under sub. (3) (c) 3. The premium amounts under sub. (3) (c) 3. shall be based on an actuarily sound charge per covered individual that is calculated to generate sufficient moneys, in conjunction with provider discounts under sub. (4), to cover the reimbursements required under sub. (2) (c).

(b) Specify the dates that apply in sub. (3) (a), subject to the dates specified in par. (c) and sub. (2) (c).

(c) Specify the dates by which a small employer insurer must forward to the board the premiums established under par. (a). The first date by which the premiums must be forwarded to the board may not be later than July 1, 2003.

(d) Specify the procedures that small employer insurers must use for collecting, segregating, holding in trust, and forwarding to the board the premiums established under par. (a).

(e) Specify the procedures that small employer insurers must use for obtaining reimbursement under sub. (2) (c), including requirements for documenting the payment of covered benefits for determining whether a small employer insurer has paid its threshold level of covered benefits.

SECTION 21. 635.30 of the statutes is created to read:

635.30 Pilot catastrophic care program. (1) In this section:

(a) "Board" means the small employer catastrophic care board.

(b) "Fiscal year" means the period beginning on July 1 and ending on the following June 30.

(c) "Fund" means the small employer catastrophic care program fund.

(d) "Health care coverage revenue" has the meaning given in s. 149.10 (3m).

(e) "Insurer" has the meaning given in s. 632.745 (15).

(f) "Program" means the pilot program established and administered under this section.

(g) "Provider" means a health care professional, as defined in s. 180.1901 (1m), a health care facility, as defined in s. 146.997 (1) (c), or a health care service or organization.

(2) ESTABLISHMENT AND ADMINISTRATION OF PROGRAM. (a) There is established a pilot catastrophic care program for employees who are eligible for coverage under group health benefit plans issued to small employers. The program shall operate for 5 years, beginning on January 1, 2003, in a region of the state that includes Winnebago County and that shall be determined and described by the commissioner by rule.

(b) The board shall oversee the operations of the program, and shall do all of the following:

1. Annually, by no later than April 30, establish a budget for the program for the next fiscal year.

2. Subject to sub. (3) (a) 4., establish the methodology for determining the premium to be charged a small employer for providing coverage under the program for an employee of the small employer.

3. Establish procedures for collecting and depositing in the fund the insurer assessments under sub. (3) (a) 2., the provider assessments under sub. (3) (a) 3., and the premiums under sub. (3) (a) 4.

4. Establish procedures for paying the costs of covered benefits for employees enrolled in the program, including procedures that small employer insurers must use for documenting and obtaining reimbursement of claims costs under sub. (6) (c), and for paying all other operating and administrative costs of the program.

5. Annually, by no later than April 30, based on data from the previous calendar year, perform a reconciliation with respect to program costs, the transfer to the fund under s. 20.145 (1) (g), insurer assessments under sub. (3) (a) 2., provider assessments under sub. (3) (a) 3., provider payment rate discounts under sub. (3) (b), and premiums under sub. (3) (a) 4. If the board determines that in the preceding calendar year the insurer assessments under sub. (3) (a) 2., or the provider assessments under sub. (3) (a) 3. in conjunction with the provider payment rate discounts under sub. (3) (b), were not equal to the transfer to the fund under s. 20.145 (1) (g), as required in sub. (3) (a) 2. and 3., the board shall make any necessary adjustments for the fiscal year beginning on the first July 1 after the reconciliation, by increasing or decreasing the insurer assessments under sub. (3) (a) 2., the provider assessments under sub. (3) (a) 3., or the provider payment rate discounts under sub. (3) (b) to reflect the amount by which the insurer assessments or provider assessments in conjunction with the provider payment rate discounts did not equal the amount of the transfer.

6. Provide for the procurement, in a competitive process, of a contract for the services of a qualified administrator to administer the program and to assist the board in its oversight of the program.

(3) PROGRAM FUNDING. (a) In establishing the annual budget under sub. (2) (b) 1., the board shall determine and approve the amount of funding needed for the fiscal year to pay the anticipated costs of covered benefits for employees enrolled in the program and all other operating and administrative costs of the program. Funding for the program shall consist of all of the following:

1. The transfer to the fund from the appropriation account under s. 20.145 (1) (g).

2. Assessments paid by insurers that are established by the board and promulgated by the commissioner by rule and that annually equal the amount of the annual transfer under subd. 1. Each insurer's share of the assessment under this subdivision shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner, and shall be in the same ratio as the insurer's total health care coverage revenue for residents of this state during the preceding calendar year bears to the aggregate health care coverage revenue of all insurers for residents of this state, as determined by the commissioner. The commissioner may by rule exempt as a class those insurers whose share would be so minimal as not to exceed the estimated cost of levying the assessment.

3. Assessments paid by providers that are established by the board and promulgated by the commissioner by rule and that, in conjunction with the provider discounts established under par. (b), annually equal the amount of the annual transfer under subd. 1. Each provider's share of the assessment under this subdivision shall be determined as provided in the rule under this subdivision. The commissioner may by rule exempt as a class those providers whose share would be so minimal as not to exceed the estimated cost of levying the assessment.

4. The premiums described in sub. (5) (c) 2., which shall be established by the board and promulgated by the commissioner by rule, and which shall be calculated on the basis of the amount by which the sum of the amounts under subds. 1. to 3. is not sufficient to pay the anticipated costs of covered benefits for employees enrolled in the program and all other operating and administrative costs of the program.

(b) 1. Subject to par. (a) 3., the commissioner by rule shall establish provider discount rates for charges for covered services provided to employees enrolled in the program.

2. Except for copayments, coinsurance, or deductibles required or authorized under the group health benefit plan for which the employee is eligible under sub. (4) (a) 1., a provider of a covered service, drug, or device shall accept as payment in full for the covered service, drug, or device the discounted payment rate under subd. 1. and may not bill the employee who receives the service, drug, or device for any amount by which the charge is reduced under subd 1.

(4) EMPLOYEE ELIGIBILITY. (a) An employee may be enrolled in the program if all of the following apply:

1. The employee is eligible for coverage under a group health benefit plan that is issued or renewed by a small employer insurer to a small employer on or between the dates specified by rule under sub. (7) (c).

2. The small employer is located in the region determined by rule under sub. (2) (a).

3. When the small employer insurer applies health status underwriting factors under s. 635.05 for determining premiums under the group health benefit plan under subd. 1., the small employer insurer determines that the employee is eligible to enroll in the program by using the guidelines established by rule under sub. (7) (a).

4. The small employer agrees to enroll the employee in the program.

5. The small employer pays the additional premium described in sub. (5) (c) 2. for the enrolled employee's coverage under the program.

(b) If an employee who is enrolled in the program becomes ineligible under par. (a), the employee may apply for coverage under the health insurance risk–sharing plan under ch. 149. If the employee applies for and obtains coverage under that plan and his or her application for coverage was received within 63 days after his or her enrollment under the program was terminated under this paragraph, the employee may not be subject to any preexisting condition exclusion under that plan.

(5) PREMIUMS. (a) For every group health benefit plan issued or renewed to a small employer that agrees to enroll in the program an employee who is eligible under sub. (4) (a), the small employer insurer shall charge a total premium that includes an amount established by rule under sub. (3) (a) 4. for the employee's coverage under the program.

(b) The small employer insurer shall forward to the board, in the manner and time required by rule under sub. (7) (d), the premium amounts that are charged for coverage under the program.

(c) In addition to the disclosures required under s. 635.11, upon the issuance or renewal of a group health benefit plan to a small employer that agrees to enroll an employee in the program, the small employer insurer shall disclose to the small employer all of the following:

1. The amount of the total premium that is attributable to coverage under the group health benefit plan for the small employer's employees who are not enrolled in the program.

2. The amount of the total premium that is attributable to an employee's coverage under the program and that is established by rule under sub. (3) (a) 4.

(d) If a small employer does not agree to enroll in the program an employee who is otherwise eligible for enrollment under sub. (4) (a), the small employer insurer issuing or renewing the group health benefit plan to the small employer may apply health status underwriting factors and determine premiums for the group health benefit plan without regard to the requirements established under s. 635.05.

(6) COVERED BENEFITS; REIMBURSEMENTS. (a) Covered benefits for an employee who is enrolled in the program are the same as the covered benefits under the group health benefit plan for which the employee is eligible under sub. (4) (a) 1.

(b) All claims for covered benefits for an employee enrolled in the program shall be processed for payment or denial by the small employer insurer issuing or renewing the group health benefit plan for which the employee is eligible under sub. (4) (a) 1.

(c) At the direction of the board, the commissioner shall reimburse a small employer insurer from the appropriation under s. 20.145 (1) (q) for the cost of claims properly paid for covered benefits for an employee enrolled in the program.

(7) RULES. The commissioner shall promulgate rules developed by the board for the operation of the program, including rules that do all of the following:

(a) Establish guidelines that small employer insurers must use for health status underwriting for determining whether an employee is eligible for enrollment under the program.

(b) Specify the dates by which the insurer assessments under sub. (3) (a) 2. and the provider assessments under sub. (3) (a) 3. must be forwarded to the board for

deposit in the fund. The earliest date specified under this paragraph must be at least 6 months before the earliest date specified under par. (c).

(c) Specify the dates that apply in sub. (4) (a) 1., subject to the requirement under par. (b).

(d) Specify the procedures that small employer insurers must use for collecting, segregating, holding in trust, and forwarding to the board, as well as the time for forwarding to the board, the premiums established under sub. (3) (a) 4.

SECTION 22. Nonstatutory provisions.

(1) SMALL EMPLOYER CATASTROPHIC REINSURANCE BOARD. Notwithstanding the length of terms specified for the members of the small employer catastrophic reinsurance board under section 15.735 (1) (b) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

(a) Two members, one nominated by the National Federation of Independent Business and Wisconsin Independent Businesses, Inc., and one nominated by the Wisconsin Association of Life and Health Insurers, Inc., for terms expiring on May 1, 2005.

(b) Three members, one nominated by the Wisconsin Association of Life and Health Insurers, Inc., one nominated by the Wisconsin Association of Health Plans, and one nominated by the State Medical Society of Wisconsin, for terms expiring on May 1, 2006.

(c) Three members, one nominated by the National Federation of Independent Business and Wisconsin Independent Businesses, Inc., one nominated by the Wisconsin Association of Health Plans, and one nominated by the Wisconsin Health and Hospital Association, for terms expiring on May 1, 2007.

(2) SMALL EMPLOYER CATASTROPHIC CARE BOARD. Notwithstanding the length of terms specified for the members of the small employer catastrophic care board under section 15.735 (2) (b) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

(a) Three members, one specified under section 15.735 (2) (a) 1. of the statutes, as created by this act, one specified under section 15.735 (2) (a) 2. of the statutes, as created by this act, and one specified under section 15.735 (2) (a) 3. of the statutes, as created by this act, for terms expiring on May 1, 2004.

(b) Four members, one specified under section 15.735 (2) (a) 1. of the statutes, as created by this act, 2 specified under section 15.735 (2) (a) 2. of the statutes, as created by this act, and one specified under section 15.735 (2) (a) 3. of the statutes, as created by this act, for terms expiring on May 1, 2005.

(c) Three members, 2 specified under section 15.735 (2) (a) 1. of the statutes, as created by this act, and one specified under section 15.735 (2) (a) 2. of the statutes, as created by this act, for terms expiring on May 1, 2006.

(3) RULES RELATED TO SMALL EMPLOYER INSURER CATASTROPHIC RISK. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may promulgate the rules required under section 635.25 (4) (a) and (5) of the statutes, as created by this act, for the period before the effective date of the permanent rules required under section 635.25 (4) (a) and (5) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b), and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of public peace,

health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

(4) RULES RELATED TO SMALL EMPLOYER CATASTROPHIC CARE. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may promulgate the rules required under section 635.30 (2) (a), (3) (a) 2., 3., and 4. and (b) 1., and (7) of the statutes, as created by this act, for the period before the effective date of the permanent rules required under section 635.30 (2) (a), (3) (a) 2., 3., and 4. and (b) 1., and (7) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b), and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

(5) PRESCRIPTION DRUG COST REDUCTION; REPORT. (a) By January 1, 2003, the department of administration shall submit a report that identifies all of the following:

1. The participation by health care providers, insurers, and self–insurers in negotiating rebate agreements under section 16.735 (2) (a) of the statutes, as created by this act, and in developing in–state or multistate purchasing groups to negotiate reduced charges under section 16.735 (2) (b) of the statutes, as created by this act.

2. Strategies that the department of administration proposes to pursue to reduce costs for prescription drugs in this state.

(b) By January 1, 2005, the department of administration shall submit a report that specifies the status of implementing section 16.735 of the statutes, as created

by this act, including any success or lack of success in reducing costs for prescription drugs in this state.

(c) The department of administration shall submit the reports specified in paragraphs (a) and (b) to the legislature in the manner provided under section 13.172 (3) of the statutes, to the members of the joint committee on finance, and to the governor.

SECTION 23. Appropriation changes.

(1) PRIVATE EMPLOYER HEALTH CARE COVERAGE PROGRAM. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of employee trust funds under section 20.515 (2) (a) of the statutes, as affected by the acts of 2001, the dollar amount is increased by $850,000 for fiscal year 2001–02 to increase funding for the purpose for which the appropriation is made.

(2) TRANSFER TO SMALL EMPLOYER CATASTROPHIC CARE PROGRAM FUND. In the schedule under section 20.005 (3) of the statutes for the appropriation to the office of the commissioner of insurance under section 20.145 (1) (g) of the statutes, as affected by the acts of 2001, the dollar amount is increased by $500,000 for fiscal year 2002–03 to increase funding for the purposes for which the appropriation is made.

SECTION 24. Effective dates. This act takes effect on the day after publication, except as follows:

(1) NOTICE OF INDEPENDENT REVIEW. The treatment of section 632.835 (2) (b) and (bg) of the statutes takes effect on the date stated in the notice published by the commissioner of insurance in the Wisconsin Administrative Register under section 632.835 (8) of the statutes.

(END)