LRB-4956

2001 DRAFTING REQUEST

Bill

Received: **02/18/2002**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Lorraine Seratti (608) 266-3780**

By/Representing: **Tim Fiocchi**

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

Drafter: **kahlepj**

May Contact:

Addl. Drafters: **champra**
kenneda
shoveme
jkreye

Subject: **Insurance - health**
Health - miscellaneous
Employ Pub - employee benefits
Tax - miscellaneous

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Seratti@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Small business health insurance reform

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlcpj 02/25/2002			_____ _____			S&L Tax

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	shoveme 02/25/2002			_____ _____			
/1	kahlepj 02/26/2002	csicilia 02/26/2002	pgreensl 02/26/2002 pgreensl 02/26/2002	_____ _____ _____ _____	lrb_docadmin 02/26/2002		State
/2	kahlepj 02/27/2002	jdyer 02/27/2002	haugeca 02/28/2002	_____ _____ _____ _____	lrb_docadmin 02/28/2002 lrb_docadmin 02/28/2002	lrb_docadmin 02/28/2002	

FE Sent For: **02/28/2002.**

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per RAC

<END>

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/2	kahlepj 02/27/2002	jdyer 02/27/2002	haugeca 02/28/2002	_____ _____ _____ _____	lrb_docadmin 02/28/2002 lrb_docadmin 02/28/2002		

Re-Submitted for Rep. Seratti (see attached e-mail from Brian Drake)

FE Sent For:

<END>

2001 DRAFTING REQUEST

Bill

Received: **02/18/2002**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Scott Jensen (608) 266-3387**

By/Representing: **Brian Dake**

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

Drafter: **kahlepj**

May Contact:

Addl. Drafters: **champra**
kenneda
shoveme
jkreye

Subject: **Insurance - health**
Health - miscellaneous
Employ Pub - employee benefits
Tax - miscellaneous

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Jensen@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Small business health insurance reform

Instructions:

See Attached

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/?	kahlepj 02/25/2002			_____ _____			S&L Tax

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	shoveme 02/25/2002			_____ _____			
/1	kahlepj 02/26/2002	csicilia 02/26/2002	pgreensl 02/26/2002 pgreensl 02/26/2002	_____ _____ _____ _____	lrb_docadmin 02/26/2002		State
/2	kahlepj 02/27/2002	jdyer 02/27/2002	haugeca 02/28/2002	_____ _____	lrb_docadmin 02/28/2002		

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<END>

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Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Scott Jensen (608) 266-3387**

By/Representing: **Brian Dake**

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

Drafter: **kahlepj**

May Contact:

Addl. Drafters: **champra**
kenneda
shoveme
jkreye

Subject: **Insurance - health**
Health - miscellaneous
Employ Pub - employee benefits
Tax - miscellaneous

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Jensen@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Small business health insurance reform

Instructions:

See Attached

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	shoveme 02/25/2002			_____ _____			
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FE Sent For:

<END>

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Drafter: **kahlepj**

May Contact:

Addl. Drafters: **champra**
kenneda
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Health - miscellaneous
Employ Pub - employee benefits
Tax - miscellaneous

Extra Copies: ↑ add Joe Kreye

Submit via email: **YES**

Requester's email: **Rep.Jensen@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Small business health insurance reform

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj	/1 cjs 2/26/02	2/26 KJF/ps	2/26 ~~KJF/ps~~ ch			

FE Sent For:

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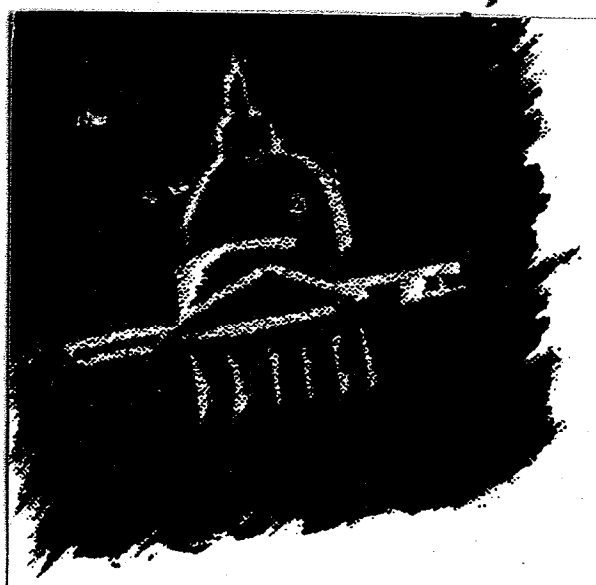

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SCOTT R. JENSEN
ASSEMBLY SPEAKER

February 18, 2002

TO: Pam Kahler
Legislative Reference Bureau

FR: Brian Dake 6-3387
Office of Assembly Speaker Scott Jensen

RE: Small Business Health Insurance Reform

For several weeks, the Small Business Health Insurance Working Group has been reviewing 2001 Assembly Bill (AB) 543 as well as other measures to reduce the costs that small businesses pay for the health insurance of their employees. The Group has come to consensus on the following proposal and to that end I would respectfully ask for the drafting of an omnibus bill encompassing each of the following elements:

1. **2001 Assembly Bill (AB) 543** with the specification that premium rates charged to small employers with similar case characteristics for the same or similar benefit design characteristics could not vary by more than 30% rather than the current 35%, above or below the midpoint premium rate for such policies.

2. **Catastrophic Care Fund Reinsurance** (see attached "A") This provision would be based on a 10/13/01 bill draft. OCI would be required to establish a reinsurance pool for small employer (2-50 employees) insurers. Draft would need to be modified to specify that it would sunset after 5 years. The pool would be funded through premiums paid by small employer insurers and by discounted reimbursement rates for health care providers established by DHFS by rules. In addition, OCI would be given the authority to provide larger reimbursement discounts for insurers that chose the higher thresholds of reinsurance coverage.

have OCI do add provider discounts

3. **Small Employer Catastrophic Care Fund** (see attached "B") This provision would be based on an 11/1/01 draft. OCI would establish a program that is similar to HIRSP except that it would cover persons with employer-based health insurance offered through a small employer (2-50 employees). This provision would need to be modified to specify that the program would be piloted in a region of the state that includes Winnebago County as determined by OCI and would be sunseted after five years. The amount of GPR appropriated would be $500,000. The amounts of the provider discounts would be established by DHFS by rule.

4. **Defined Contribution Plan.** This provision would require ETF to offer non-representative employees of the state of Wisconsin a defined benefit contribution plan once such a program has been made available to citizens in the state of Wisconsin. Furthermore, such providers of defined benefit contribution plans would be required upon request to provide prices to individuals who carry a defined contribution plan.

5. **Medical Savings Accounts.** This provision would require federalization of Wisconsin's statutes relating to medical savings accounts and require that any future changes to federal medical savings account statutes would automatically be adopted into Wisconsin state statutes.

6. **Prescription Drug Purchasing Consortium.** Drafting instructions to be provided by Rachel Carabell at Legislative Fiscal Bureau.

Tom Korpady

(A)

CATASTROPHIC CARE FUND REINSURANCE PROVISIONS FOR HEALTH BENEFIT PLANS OFFERED IN THE SMALL GROUP MARKET BY SMALL EMPLOYER INSURERS

AN ACT *to create* s. 635.20; **relating to:** threshold levels of covered benefits for health benefit plans offered in the small group market by small employer insurers, establishment of the small employer catastrophic reinsurance board and the small employer catastrophic care fund; and granting rule-making authority.

Analysis by the Legislative Reference Bureau

SECTION 1. 635.20 of the statutes is created to read:

635.20 Small Employer Catastrophic Risk. (1) THRESHOLD LEVELS OF COVERED BENEFITS FOR SMALL EMPLOYERS

(a) The commissioner shall provide by administrative rule for the selection by small employer insurers of uniform statewide threshold levels of covered benefits that will be paid under health benefit plans offered in the small group market by small employer insurers.

(b) A small employer insurer must specify and report to the commissioner not later than 60 days after the effective date of the rule to be promulgated by the commissioner under par. (a), and thereafter must report every 2 years, and not later than December 1 of the year in which the report is due, the small employer insurer's

uniform statewide threshold level of covered benefits that will be paid under each and all of the small employer insurer's health benefit plans offered in the small group market, which shall be one of the following amounts per insured individual:

1. $50,000 in a calendar year.
2. $100,00 in a calendar year.
3. $150,000 in a calendar year.
4. $250,000 in a calendar year.

(c) The uniform specified statewide threshold level of covered benefits selected by a small employer insurer under par. (b) shall determine the small employer insurer's liability per insured individual for covered benefits up to that threshold level under each and all of the small employer insurer's health benefit plans offered in the small group market in each of the next two calendar years after the report is filed by the small employer insurer under par. (b).

(d) Covered benefits paid in any calendar year by a small employer insurer under a health benefit plan offered in the small group market for a covered individual for amounts in excess of the threshold level of covered benefits in effect under pars. (b) and (c) shall be deemed to constitute catastrophic care benefits for purposes of reimbursement by the small employer catastrophic care fund under sub. (3) (b). The effective date for dates of service of covered benefits deemed to constitute catastrophic care benefits on and after which the threshold provisions under sub. (3) (b) shall first be applied shall be established by the rule to be promulgated by the commissioner under sub. (3) (d).

(e) The commissioner shall specify in the rule under par. (a) the procedures to be used by small employer insurers to properly document payment of the threshold level of covered benefits in effect under pars. (b) and (c) under an insured individual's health benefit plan before payment or reimbursement of catastrophic care benefits may be made from the small employer catastrophic care fund under sub. (3) (b).

(f) Each small employer insurer shall disclose in any offer to insure small employer health benefits the uniform specified statewide threshold level of covered benefits selected by the small employer insurer under par. (b), and in establishing and charging premium for any health benefit plan offered in the small group market each small employer insurer shall provide a breakdown of premium amounts to clearly show:

1. The premium amount or amounts which are charged to provide coverage for the threshold level of covered benefits selected by the small employer insurer under par. (b) and to provide coverage for 20 percent of the covered benefits deemed to constitute catastrophic care benefits under par. (d).

2. The premium amount or amounts established by the board under sub. (2) which are charged for operating and administrative costs of the small employer catastrophic care fund under sub. (3).

(2) SMALL EMPLOYER CATASTROPHIC REINSURANCE BOARD

(a) The small employer catastrophic reinsurance board shall consist of the commissioner and eight members appointed by the governor. The governor may remove a member of the board for just cause. The eight appointed members, who shall serve for staggered 3-year terms, shall be:

1. Two small employer members appointed from among candidates nominated by the national federation of independent business and Wisconsin independent business inc.

2. Two small employer insurer members appointed from among candidates nominated by the Wisconsin association of life and health insurers, Inc.

3. Two small employer insurer members appointed from among candidates nominated by the Wisconsin association of health plans.

4. One physician member appointed from among candidates nominated by the state medical society of Wisconsin

5. One hospital member appointed from among candidates nominated by the

Wisconsin health and hospital association.

(b) The chairperson of the board shall be elected annually for a one-year term by a majority vote of the board's members.

(c) A majority of five of the board's nine members constitutes a quorum, and a majority of a quorum may act on any matter within the jurisdiction of the board.

(d) The board shall be free to organize its own operations and activities, and may establish an office of the board to perform those duties assigned by the board and may hire employees of the office of the board and fix compensation, except that where the board can rely on existing state or other government staff and operations there shall be no duplication of such staff and operations by the office of the board.

(e) Members of the board may not be compensated for their services, but members shall be reimbursed by the board for their actual and necessary expenses incurred in the performance of their duties.

(f) The board and the office of the board established under this section shall seek to be exempt from taxation under section 501 of the internal revenue code.

(g) For purposes of indemnification, ss. 181.041 to 181.044, as they apply to directors and board members of nonstock corporations with respect to nonstock corporations under ch. 181, shall apply to members of the board and the subcommittees of the board established under this section.

(h) No cause of action of any nature may arise against and no civil liability may be imposed upon a member of the board, or a subcommittee of the board, or an employee of the board, or a person acting on behalf of the board, or a participant under Ch. 133 for any act or omission in the performance of his or her powers and duties within the scope of this section, unless the person asserting liability proves that the act or omission constitutes wilful misconduct.

(3) SMALL EMPLOYER CATASTROPHIC CARE FUND. The small employer catastrophic care fund shall be a fund into which shall be deposited the small employer catastrophic care fund premium amounts under sub. (1) (f) 2., which

shall be determined and periodically adjusted by the board under the rule to be developed and promulgated under par. (d), and from which shall be disbursed all funds required to pay or reimburse the operating and administrative costs of the fund.

(a) The small employer catastrophic reinsurance board under sub. (2) shall oversee the operations of the small employer catastrophic care fund.

(b) The board shall ensure that the small employer catastrophic care fund shall pay or reimburse a small employer insurer for the costs of 80 percent of covered benefits deemed to constitute catastrophic care under sub. (1) (d) for a covered individual, but only after the small employer insurer has first properly paid the threshold level of covered benefits under sub. (1) (b) and (c) which is the threshold liability of the small employer insurer providing coverage under the covered individual's health benefit plan.

(c) The board shall also ensure that a small employer insurer shall pay 20 percent of covered benefits deemed to constitute catastrophic care under sub. (1) (d) for a covered individual, which shall be the catastrophic care liability of the small employer insurer providing coverage under the covered individual's health benefit plan.

(d) The board shall develop and adopt rules, subject to approval by the commissioner, which shall be promulgated by the commissioner to govern the operation of the small employer catastrophic care fund, and which shall, at a minimum:

1. Provide that the board shall determine and periodically adjust the small employer catastrophic care fund premium amount or amounts to be included by all small employer insurers under sub. (1) (f) 2. in all premiums charged and collected for health benefit plans offered in the small group market. The catastrophic care premium amount or amounts to be determined and periodically adjusted by the board shall be actuarially sound charges per covered individual calculated to generate sufficient revenue to cover the payments to be made out of the fund for 80 percent of

the costs of covered health care treatment or services deemed to constitute catastrophic care under sub. (1) (d) for all covered individuals, and for all other operating and administrative costs of the fund.

2. Provide that the small employer catastrophic care fund premium amount or amounts charged by a small employer insurer under sub. (1) (f) 2. shall vary among small employer insurers according only to the different uniform threshold levels of covered benefits specified and reported to the commissioner by small employer insurers under sub. (1) (b), consistent with such actuarially sound methodology as the board may wish to adopt.

3. Establish the date on and after which the small employer catastrophic care fund premium amount or amounts under sub. (1) (f) 2. shall be charged, collected and forwarded for deposit in the small employer catastrophic care fund by all small employer insurers.

4. Establish the effective date for dates of service of covered benefits deemed to constitute catastrophic care benefits on and after which payments or reimbursements under par. (b) shall be made from the fund, which shall be a date at least six months after the date under subd. 3.

(4) No small employer insurer may waive or otherwise fail to charge or collect the separate premium amount or amounts for operating and administrative costs of the small employer catastrophic care fund required under sub. (1) (f) 2. for all health benefit plans offered in the small group market.

(5) Each small employer insurer shall properly segregate and forward to the small employer catastrophic reinsurance board under sub. (2) the separate premium amount or amounts for operating and administrative costs of the small employer catastrophic care fund required under sub. (1) (f) 2. for all health benefit plans offered in the small group market in such manner as the small employer catastrophic reinsurance board under sub. (2) shall so direct.

(END)

AB650 mod changes to 181

181.0871 to ~~0884~~ 181.0874

895.46 (4)

893.82(2)(d) 3.

Why have an effective date for services because it applies to a calendar yr

If so, what does effective date of cov serv mean?

add to rules → procedures for documenting payment of ben

some of the rules are not nec

add: in disclosing premium breakdown –

(2) which portion goes to cov up to thres + 20% of cost over thres

(3) which portion goes to ~~ß~~ fund to cover 80% of all ben paid over thres

(1) threshold of insurer

add: bd ensure that premiums are paid

deposit premium

vary prem only by threshold selected by ins

2002 → 2003 + 2004, 2005 + 6, 2007 + 8

~~2004 + 5~~ ~~2006-7~~ ~~2008-9~~

(B)

SMALL EMPLOYER CATASTROPHIC CARE FUND

AN ACT *to create* s. 635.20; **relating to:** establishment of the small employer catastrophic care fund and the small employer catastrophic care fund governing board; eligibility and health underwriting of individuals for enrollment in the small employer catastrophic care fund; covered benefits, claims processing and reimbursement of small employer insurers for claims paid for individuals enrolled in the small employer catastrophic care fund; small employer catastrophic care fund administration, budgets, and revenues; and granting rule-making authority.

Analysis by the Legislative Reference Bureau

SECTION 1. 635.20 of the statutes is created to read:

635.20 Small Employer Catastrophic Care Fund. (1) The small employer catastrophic care fund shall be a fund into which shall be deposited the small employer catastrophic care fund revenues under sub. (6), and from which shall be disbursed all monies required to pay or reimburse the operating and administrative costs of the fund.

(a) The small employer catastrophic care fund governing board under sub. (2) shall oversee the operations of the small employer catastrophic care fund.

(b) In overseeing the operations of the small employer catastrophic care fund, the small employer catastrophic care fund governing board under sub. (2) shall, at a minimum:

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

for the fund.

2. Establish the methodology to be used to determine the small employer catastrophic care fund premium amount or amounts to be charged by small employer insurers under sub. (5) (b) in order to generate the small employer catastrophic care fund premium revenues required under sub. (6) (d).

3. Establish procedures for payment by the fund for the costs of covered benefits under sub. (4) (c) for all eligible individuals enrolled in the fund as provided under sub. (3), and to pay for all other operating and administrative costs of the fund.

4. Provide for the collection, deposit and disbursement of the small employer catastrophic care fund revenues specified under sub. (6). In setting the insurer assessments under sub. (6) (b), and the provider assessments under sub. (6) (c), the board shall include any increase or decrease necessary to reflect the amount, if any, by which the insurer assessments under sub. (6) (b), or the provider assessments under sub. (6) (c) were not equal to the general purpose revenues under sub. (6) (a) in the preceding calendar year, as determined by the annual reconciliation under subd. 5.

5. Annually, no later than April 30, perform a reconciliation with respect to fund costs, general purpose revenues under sub. (6) (a), insurer assessments under sub. (6) (b), provider assessments under sub. (6) (c), and small employer catastrophic care fund premiums under sub. (6) (d) based on data from the preceding calendar year. If the board determines that the insurer assessments under sub. (6) (b), or the provider assessments under sub. (6) (c) were not equal to the general purpose revenues under sub. (6) (a) in the preceding calendar year, the board shall make any necessary adjustments in the insurer assessments under sub. (6) (b), or the provider assessments under sub. (6) (c) for the fiscal year beginning on the first July 1 after the reconciliation, as provided under subd. 4.

6. Provide for the competitive contract procurement of the services of a qualified administrator to administer the operations of the fund and to support the

board in its oversight of fund operations.

(c) The board shall develop and adopt rules, subject to approval by the commissioner, which shall be promulgated by the commissioner to govern the operation of the small employer catastrophic care fund, and which shall, at a minimum:

1. Establish guidelines that shall be used by each small employer insurer to determine that an individual is eligible for enrollment in the small employer catastrophic care fund, as provided under sub. (3) (c), when the small employer insurer develops and applies health underwriting premium rating factors, as provided under s. 635.05 (a) 2., for a health benefit plan offered in the small group market, as provided under sub. (3) (d).

2. Establish the date or dates on and after which the revenues under sub. (6) (a), (b), and (c) shall be obligated or assessed and deposited in the small employer catastrophic care fund, and on and after which the revenues under sub. (6) (d) shall be charged, collected and forwarded for deposit in the small employer catastrophic care fund by all small employer insurers, and any related administrative provisions or regulatory requirements.

3. Establish the effective date on and after which the fund shall make the sub. (1) (b) 3. payments to small employer insurers for the costs of covered benefits paid for eligible individuals enrolled in the fund, which shall be a date at least six months after the date under subd. 2, and any related administrative provisions or regulatory requirements.

(2) SMALL EMPLOYER CATASTROPHIC CARE FUND GOVERNING BOARD (a) The small employer catastrophic care fund governing board shall consist of the commissioner and ten members appointed by the governor. The governor may remove a member of the board for just cause. The ten appointed members, who shall serve for staggered 3-year terms, shall be:

1. Four small employer members who shall represent small employers.

2. Four small employer insurer members who shall represent small employer insurers.

3. Two members who shall represent the medical community, at least one of which shall be a physician.

(b) The chairperson of the board shall be elected annually for a one-year term by a majority vote of the board's members.

(c) A majority of six of the board's eleven members constitutes a quorum, and a majority of a quorum may act on any matter within the jurisdiction of the board.

(d) The board shall be free to organize its own operations and activities, and may establish an office of the board to perform those duties assigned by the board and may hire employees of the office of the board and fix compensation, except that where the board can rely on existing state or other government staff and operations there shall be no duplication of such staff and operations by the office of the board.

(e) Members of the board may not be compensated for their services, but members shall be reimbursed by the board for their actual and necessary expenses incurred in the performance of their duties.

(f) The board and the office of the board established under this section shall seek to be exempt from taxation under section 501 of the internal revenue code.

(g) For purposes of indemnification, ss. [redacted], as they apply to directors and board members of nonstock corporations with respect to nonstock corporations under ch. 181, shall apply to members of the board and the subcommittees of the board established under this section.

(h) No cause of action of any nature may arise against and no civil liability may be imposed upon a member of the board, or a subcommittee of the board, or an employee of the board, or a person acting on behalf of the board, or a participant under Ch. 133 for any act or omission in the performance of his or her powers and duties within the scope of this section, unless the person asserting liability proves that the act or omission constitutes wilful misconduct.

(3) ELIGIBILITY AND HEALTH UNDERWRITING OF COVERED INDIVIDUALS An individual is eligible for enrollment in the small employer catastrophic care fund under sub. (1) if all of the following apply:

(a) The individual is eligible for coverage under a health benefit plan offered by a small employer.

(b) The health benefit plan under par. (a) under which the individual is covered is a health benefit plan offered by a small employer insurer in the small group market.

(c) When the small employer insurer under par. (b) offering the health benefit plan under par. (a) develops and applies health underwriting premium rating factors, as provided under s. 635.05 (a) 2., for the health benefit plan under par. (a), the small employer insurer underwrites the health status of the individual to establish the individual's eligibility for enrollment in the small employer catastrophic care fund, as provided by the rule under sub. (1) (c) 1.

(d) The small employer insurer under par. (b) offering the health benefit plan under par. (a) and underwriting the health status of the individual under par. (c), shall perform such underwriting only upon application by the small employer for the coverage under par. (a) or upon renewal of the coverage under par. (a) for which the individual is eligible.

(e) The small employer under par (a) agrees to enroll the individual in the small employer catastrophic care fund under sub. (1).

(g) The small employer under par. (a) properly pays the premium amount or amounts charged by the small employer insurer under sub. (5).

(4) COVERED BENEFITS, CLAIM PROCESSING AND CATASTROPHIC CARE FUND REIMBURSEMENTS. (a) Covered benefits for an individual enrolled in the small employer catastrophic care fund shall be the covered benefits under the individual's health benefit plan under sub. (3) (a).

(b) All claims for covered benefits for an individual enrolled in the small employer catastrophic care fund shall be processed for payment or denial by the small

employer insurer providing coverage for the individual under sub. (3) (b) under the terms and conditions of the small employer health benefit plan under sub. (3) (a) under which the individual is covered.

(c) A small employer insurer who has processed and paid claims for covered benefits for an individual enrolled in the small employer catastrophic care fund shall be reimbursed by the small employer catastrophic care fund as provided under sub. (1) (b) 3. for the claims cost properly paid under pars. (a) and (b).

(5) PREMIUM CHARGES A small employer insurer shall disclose, in establishing and charging premiums for any health benefit plan offered in the small group market, a breakdown of premium amounts to clearly show, at a minimum:

(a) The premium amount or amounts charged by the small employer insurer to provide benefits under the health benefit plan for all eligible individuals who are not eligible for enrollment in the small employer catastrophic care fund.

(b) The small employer catastrophic care fund premium amount or amounts consistent with the revenue requirements under sub. (6) (d) charged by the small employer insurer to provide benefits under the health benefit plan for all eligible individuals who are enrolled in the small employer catastrophic care fund.

(6) SMALL EMPLOYER CATASTROPHIC CARE FUND REVENUES In establishing the annual fiscal year budget for the small employer catastrophic care fund, as provided under sub. (1) (b) 1., the board shall approve the revenues needed by the fund to pay the expected fiscal year costs of covered health care treatment or services for all eligible individuals enrolled in the fund and all other operating and administrative costs of the fund, and the commissioner shall by rule provide for such fund revenues, which shall consist of the following:

(a) The general revenue appropriation for the small employer catastrophic care fund provided for in the fiscal year general executive budget, or otherwise appropriated by the state.

(b) Separate revenues equal to the small employer catastrophic care fund

revenues appropriated under par. (a), to be generated by assessments levied by the commissioner on all insurers as defined under s. 632.745 (15).

1. Each insurer's share of the assessment shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner, and shall be determined in proportion to the ratio of the insurer's total health care coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all insurers for residents of this state during the preceding calendar year, as determined by the commissioner, except that the commissioner may by rule exempt as a class those insurers whose share would be so minimal as to not exceed the estimated cost of levying the assessment.

(c) Separate revenues equal to the small employer catastrophic care fund revenues appropriated under par. (a), to be generated by assessments levied on all providers of health care services in the state as defined under s. 609.01 (5m).

1. Each provider's share of the assessment shall be determined annually by the commissioner in such manner as shall be determined by the small employer catastrophic care fund governing board and the commissioner by rule.

(d) Separate revenues to be generated by collection of the small employer catastrophic care fund premiums charged by small employer insurers under sub. (5) (b) for each eligible individual enrolled in the small employer catastrophic care fund, which shall be calculated to generate an amount needed in excess of the combined revenues available under pars. (a), (b), and (c) which shall be sufficient to allow payments to be made by the fund, as provided under sub. (1) (b) 3., for the expected costs of covered health care treatment or services for all eligible individuals enrolled in the fund, and for all other operating and administrative costs of the fund.

(7) Each small employer insurer shall properly segregate and forward to the small employer catastrophic care fund governing board under sub. (2) the separate small employer catastrophic care fund premium amount or amounts for operating and

administrative costs of the small employer catastrophic care fund charged by the small employer insurer under sub. (5) (b) in such manner as the small employer catastrophic care fund governing board under sub. (2) shall so direct.

(8) An individual enrolled in the small employer catastrophic care fund who is no longer eligible under sub. (3) for coverage under the fund may apply for coverage under the health insurance risk sharing plan under chapter 149. If the individual's application for coverage under the health insurance risk sharing plan under chapter 149 is received by the department of health and family services not later than 63 days after the individual's coverage under the small employer catastrophic care fund has terminated, the preexisting condition limitations under s. 149.14 (6) shall be waived by the department in processing the individual's application.

(9) If a small employer under sub. (3) (e) declines to enroll an eligible individual in the small employer catastrophic care fund, as permitted under sub. (3) (e), the small employer insurer under sub. (3) (c) and (d) may health underwrite and charge premiums for the health benefit plan under sub. (3) (c) and (d) without regard to ss. 635.05 and 635.20.

(10) The office of the commissioner of insurance may use the procedure under section 227.24 of the statutes to promulgate rules authorized under sections 635.20 (1) (c), 635.20 (6), and 635.20 (6) (c) 1. of the statutes, as created by this act. Notwithstanding sections 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.

(END)

Topic of the Month

Tufts Managed Care Institute—January 2001

Defined Contribution: Overview and Resources

To open the new year, we present an overview of defined contribution, a marketplace phenomenon garnering a good deal of attention. Defined contribution is a new approach to employer-based health insurance coverage that could change in major ways the roles and relationships among consumers, health plans, purchasers and providers.

For several decades we have grown accustomed to a health care financing system in which employers purchase and help administer insurance on behalf of their employees, and employees select from the limited number of plans offered by their employers. Defined contribution shifts the dynamic: while employers continue to contribute their share of the costs, employees now assume more of the decision-making as to plan, benefits, and level of expenditure. The model for this arrangement is the 401(k) pension, in which employees are given a fixed amount of money, a series of investment options, and the flexibility to manage their own retirement portfolios.

Defined contribution is one manifestation of the consumerism that we see in many sectors of our society. It stems from the notion that increasing flexibility and choice also increases buyer satisfaction. But to be most effective it requires educated consumers. People need good information in order to choose wisely to meet their specific needs and desires. As they compare and evaluate their options, consumers will learn more about health care and the relationships and trade-offs between price, choice and access-issues that managed care has introduced to the marketplace. With a clearer sense of the financial implications, many consumers may be more accepting of cost control tools and techniques such as formularies, referral management and practice guidelines.

Employer Issues

Why would employers consider defined contribution plans? One key impetus is their frustration with the current system and the rising costs of insurance; employers are looking for alternatives that might save them money over time. A related reason is to relieve themselves of the administrative hassles and expenses of managing benefits and dealing with health plans. They may view this as a way of offering more choices of health plans to their employees. The success of pension plans provides a precedent for shifting control to employees. The precise level of employers' interest in defined contribution plans is difficult to measure, as different surveys have yielded different findings. But expert observers expect the approach to take hold over the next few years.

Implementation Models

There are various models of how defined contribution would work in practice. At one end of the spectrum is a pure individual, nongroup market model, where employees are given money and left to their own devices to find insurance. Moving along the spectrum, there are models where employees are given a menu of choices assembled by the employer or an intermediary broker. These choices could include several benefit packages from a small number of health plans, such as closed-panel HMO or PPO products, high premium / low deductible packages or the reverse, and catastrophic care or comprehensive care. The goal here is to allow the enrollee to customize

TUFTS MANAGED CARE INSTITUTE

his or her individual or family coverage, based on personalized considerations of value, quality and price. This system has much in common with the "managed competition" model advocated in the 1980s and 1990s as a way of controlling health care costs.

In all descriptions of defined contribution, the internet plays an important role. Through the web, employees will access information about their options, make their choices, administer their benefits, and monitor their spending. Companies that can manage these e-commerce functions will emerge as a new player in the health care financing system.

Obstacles and Challenges

There are a number of outstanding questions and concerns that will impact the development of defined contribution. One major issue is how regulations and tax laws now governing employer-based coverage would apply to this new system in which individuals are in effect given money instead of benefits; will employers and employees have the same tax advantages under defined contribution plans as they currently have under defined benefit plans? Another concern is the complexity of the information requirements and how to make the system work for consumers; compared to pension plans and their investment options, health insurance coverage has many more variables, such as provider panels, benefit options, needs of family members, and quality data.

Perhaps the most fundamental concern has to do with risk pools and adverse selection. As individuals are free to construct their own benefit packages based on their self-perceived needs, healthy individuals are likely to select the least expensive, highest deductible plans. This conflicts with the needs of insurance underwriters for a balance of sick and healthy enrollees to make the plan financially viable. Suggested solutions include the use of purchasing pools, regulatory changes, or keeping the employer as the risk pool entity.

Provider Implications

What will defined contribution mean for physicians, hospitals and other providers? The prevailing wisdom is that the choices that individuals make regarding how they spend their contribution will include not only insurer and benefits, but also physicians and hospitals. While managed care enrollees now select their personal physician primarily from printed lists, in the future they will be provided much more detailed profile information online at their designated website. Employees are likely to be very quality-conscious, and they will consider provider-related items such as convenient locations, short waiting times, attractive facilities, adequate face-to-face physician time, reasonable charges, access to educational information, and physician's internet access. Physicians will need to adapt to this increasingly competitive marketplace.

A related dramatic development for both providers and health plans is the emergence of companies that enable consumers to use their defined contribution to customize their benefits and choose their providers, without enrolling in an established health plan. These new entities seek to sign on providers who constitute their participating panel, but without the involved arrangements and controls imposed by managed care organizations. One example is Vivius Inc.(http://www.vivius.com/), which calls itself a "personalized health care system" in which participating physicians, hospitals, and other providers set their own payment rates, and each employee chooses a personal physician, hospital, pharmacy network, medical lab and radiology clinic, and about fifteen specialty physicians, as well as their

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own level of co-payment for these providers. Another new company promising to restore physician autonomy and remove external controls, while enabling consumers to exercise greater choice and control, is Definity Health (http://www.definityhealth.com).

A year from now, perhaps longer, many Americans may be obtaining their health insurance and arranging their medical services in very different ways than our current practices. Health care professionals will want to follow these developments to make sure they work to the benefit of our patients and enrollees.

Sites providing lists of and links to online reports and articles:

- Defined Care Resource Center and Article Library http://www.definedcare.com/
- MyHealthBank, Industry Trends http://www.myhealthbank.com/

Selected articles and reports:

- Aquilina D. Will Consumer-Driven E-Health Plans Reward Physicians for Quality? The Quality Indicator Physician Resource. December 2000. http://www.qiphysician.com/
- Costello MA. New voucher-type coverage plans make their way into health care scene. AHA News, May 22, 2000. http://www.ahanews.com/ (Article Archive)
- Jacob J. Defined benefits: multiple choice. American Medical News, May 1, 2000. http://www.ama-assn.org/sci-pubs/amnews/pick_00/bisa0501.htm
- New directions in employer -sponsored health care. Healthcare Business. May 2000. Supplement: Roundtable. http://www.healthcarebusiness.com/archives/healthcarebusiness/0500/index.html
- Press C. A future with defined contribution health plans. Health care Forum Journal. November/December 2000;43(6). http://www.healthforumjournal.com (Article Archive)
- Reinventing health care benefits: understanding defined contribution models, self-directed health plans and online benefits management. Health care Business. November/December 2000. Supplement: Roundtable. http://www.healthcarebusiness.com/archives/healthcarebusiness/current/rt-feature.html
- Roniger LR. Emerging markets: E-benefits: beyond managed care. Health care Business. September 2000. http://www.healthcarebusiness.com/archives/healthcarebusiness/0900/dept-emerging.html
- Scandlen G. Defined contribution health insurance. National Center for Policy Analysis. Policy Backgrounder No. 154, October 26, 2000. http://www.ncpa.org/bg/bg154/bg154.html

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Health Care News
August 2001
Contents

The Defined Contribution Health Benefit: *A Practical Primer*

The future of health care financing in America is at a crossroads. Building a sustainable framework for providing health care benefits depends on reorienting our current system toward consumer-oriented, defined contribution models.

by Stephen Barchet, M.D.

A defined contribution approach to health care creates a new, more sustainable financial framework for an employer seeking to provide its employees with health benefits and purchase health plan coverage. This framework establishes clearly and predictably how much the employer will contribute to benefits.

In its fullest expression, the defined contribution also distances employers from health plan selection. It permits employees to directly control the range of health plans they may consider, producing a real sense of ownership over their eventual plan choice.

A defined contribution approach has the following main features:

- **Fixed employer contribution.** The employer decides upon a fixed amount to pay for health plan coverage for all employees.
- **Many plan options.** The employer presents employees with a choice of different health plans with varying deductibles, co-payments, health management styles (health maintenance organizations versus preferred provider organizations), and premiums.
- **Employee selects plan.** Employees choose from the menu of health plans available and presented by the employer.
- **Employee pays difference.** Employees pay the difference between the amount contributed by the employer and the cost of the coverage for the plan they select.
- **Employer pays health plan.** The employer pays the premium for coverage directly to the health plan.
- **Employee controls coverage.** Employees are free to remain with the health

plan they initially selected or seek another health plan that better meets their needs.

In a defined contribution approach, employer contributions for health benefits are clearly labeled a part of total compensation for employees. Each employee is compensated with a fixed contribution. The fixed contribution generally is determined by the employer and can be based on a large number of considerations allowed under current law and regulations.

They can include the historical level of the health plan premium, a fixed annual percent increase such as 5 percent, a variable amount based on health cost increase trends, and/or any variation based on profitability, net revenue, productivity improvement, or other economic or performance-related measure.

Under the defined contribution approach, an employer can make the amount of the defined contribution equal for each employee or vary it based on a variety of factors such as number of family members, job classification, performance appraisal results, length of employment, divisional performance, or additional factors allowable under existing benefit laws and regulations.

When given a *choice,* some employees prefer to take a plan with higher co-pays or elect to change doctors or use their spouse's health benefit plan. But employees rarely are given these options in the typical group plan offered by small employers. Instead, the employee must select one health plan with limited benefit coverage and point-of-use cost sharing--in addition to the inevitable, irritating administrative requirements. Employee choice of health plans consistently emerges as one of the most highly valued features of a benefit program.

Our current health benefits arrangements are contributing to the rapidly escalating cost of health plan coverage. Furthermore, the rate of increase for health coverage is far higher than all other cost increases for most employers. This rapidly growing component acts to reduce the funds available to pay cash compensation to employees or provide other benefits and, on a global level, reduces the competitiveness of the products and services of American companies. This situation is not sustainable over the long haul for either small employers or their employees and family members.

If employers and employees hope to maintain long-term satisfaction with their health coverage, a positive alternative in offering and paying for health insurance is badly needed. A "defined contribution" approach is a workable and positive solution. It involves employees more directly in the process of selecting and paying for health coverage, and it can be structured and implemented with considerable flexibility. With defined contribution, the employer may customize the company's benefits-compensation strategy and offer a plan that meets its needs and employees' needs.

Many Options

Employers have four options in providing employees a choice of plans. These include:

- Group health plans
- Individual health plans
- Group and individual health plans

- Allow individuals to find their own health plan

OPTION ONE: Group policies typically have more lenient underwriting provisions (that is, coverage is more readily available to employees with health problems), more generous contract provisions, and/or lower cost. Group policies usually require most if not all eligible employees to participate, and many insurance companies are not eager to give employees in small companies a choice of plans.

OPTION TWO: The employer provides access to a number of individual plans. The employer does not have to worry about participation requirements and can usually offer more choices to employees. Employees own the policies, so each policy is fully portable.

OPTION THREE: The employer offers both group and individual policies.

OPTION FOUR: The employer provides individual employees with the choice of finding their own health plan. Employees might select from among traditional indemnity plans, preferred provider organizations (PPOs), point-of-service (POS) plans, and health maintenance organizations (HMOs).

Employee Selects the Plan

Under a defined contribution approach, each employee can choose from the health plans offered by the employer the one that best fits his or her individual circumstances. The employer may decide to make information from a number of health plans available to employees in a standard format for comparison. Employees may select their health plan based on any number of criteria, such as those outlined in Figure One.

Employees are likely to be more satisfied once they have the ability to choose, especially when their decisions are supported by reliable and relevant information about the features and characteristics of each health plan. The company's personnel compensation staff can coordinate the plan selections, insurance company billings, and monthly premium payments, or the company may choose to hire an outside administrator to manage the process.

Stephen Barchet, M.D. is manager of the Defined Contribution Project at the Evergreen Freedom Foundation. This summary is taken from his Defined Contribution Health Benefits: Enabling Employee Choice. A Practical Primer for Employers, *published in April 2001 by Evergreen.*

For more information . . . contact Lynn Harsh, executive director of the Evergreen Freedom Foundation, at 360/956-3482 or email effwa@effwa.org. The full text of Dr. Barchet's report is available for a suggested contribution of $25; an online ordering form can be found at **http://effwa.org/website/DCHBorderform.htm.**

■ Employee Benefits
March/April 2001. Vol. 12, No. 2

New trends in health insurance plans

by Debbie Kuehn

An aging population, growing pharmaceutical costs, and increasingly expensive technology are just a few of the reasons employers continue to experience double-digit increases on their health insurance plans. Considering that 30 percent of an employer's budget typically goes to medical benefits, this tab can add up quickly.

Some experts project healthcare cost increases of about 10- 15 percent for the year 2001. Others foresee 16-20 percent cost increases with small employers being hit the hardest. Despite these increases, experts believe revolutionary changes are underway in the healthcare market that could lead to lower costs. Some trends include defined contribution health-care plans, using the Internet to lower healthcare plan costs, implementing wellness programs, monitoring vendor performance, and astutely evaluating healthcare plan options.

Defined contribution healthcare plans

One alternative to conventional delivery of employee health coverage is the defined contribution health plan. While many employers already define their contributions to health coverage through a flexible benefit program, defined contribution plans take this one step further.

Employers still provide contributions on behalf of employees, but they do not limit plan choices to the few usually offered through a flexible benefit program. Instead, employees design their own plan based on services available in their area. Employees obtain information on plans, providers, price, and other variables, and in some cases can do enrollment on the Internet.

Experts see both pros and cons to defined contribution healthcare delivery. On the con side, some think large-scale adoption of the defined contribution model is years away because it is not realistic in the current marketplace. Although this approach can control costs, employers are wary of being the first to apply it to their own healthcare plans. Some employers would rather assume cost increases than risk alienating good employees in a tight labor market.

On the pro side, defined contribution plans can reduce employer costs through easier administration; give employees more control over plan design; and increase employee satisfaction. In addition, the healthcare industry is standardizing and expanding consumer information, creating the first real retail market for health insurance.

Using the Internet

Internet-based approaches to delivering healthcare plans have become increasingly attractive to employers who are looking to offer their employees more choice and control, while at the same time, creating a more predictable expenditure for their healthcare benefit costs.

One such Internet-based plan is the Vivius Personalized Health System. Borrowing elements from both managed care and indemnity plans, this new healthcare purchasing system lets consumers customize their own healthcare benefits. Using the Vivius web site, consumers select the individual physicians, hospitals, and other healthcare providers that meet their budgets and needs. Providers on the Vivius web site set their own fees and market their services to consumers.

Vivius allows employers to lay the groundwork for a defined contribution plan without having to completely abandon an existing defined benefits plan. Employers work with Vivius to establish a "healthcare purchasing account," which is a pre-defined amount of money that employees can apply toward purchasing healthcare services. The healthcare purchasing account can be set up using a variety of mechanisms that many companies already have in place today, such as a Section 125 flexible spending plan. Employers also benefit because the Vivius model is designed to generate fewer benefit-related questions and complaints from employees—all without overhauling the legal and tax structures of a company's existing benefit plan.

Like defined contribution plans, the Vivius plan establishes an annual healthcare spending account for each employee. The employee then builds his or her own network choosing a primary care physician, specialist, and other providers from a web site. No claim forms, pre-certifications, or medical necessity determinations are needed. Participating providers set their own monthly fees. Employees indicate the amount of out-of-pocket expenses they want to assume. The web site then calculates the premium based on those preferences.

This online one-stop shopping experience is part of a trend called e-healthcare. It is a trend that improves healthcare plan choice, administrative efficiencies, and access. It can also save employers money in enrollment costs. Whereas a telephone call-in employee healthcare plan enrollment service can cost between $12 and $15 per employee, web-based enrollment can reduce those costs to about $1 to $2 per employee. Also, e-healthcare not only makes it easier for employers to give

employees more control over healthcare purchasing, it also helps employees become more educated and confident buyers of healthcare.

Significant cost reductions in healthcare become a reality with an effective wellness program.

Wellness programs

As the body mass index for Americans increases, so do the number of sick days, medical claims, and health-care costs faced by employers. This is one reason employers are exploring ways to help employees use their healthcare plans more wisely through prevention and well-ness programs. Wellness programs can yield benefits for employees and employers alike.

Wellness programs help employees understand their current health status, learn how to lower their health risks, and lead healthier, happier lives. Healthier employees also tend to have a higher level of job satisfaction and lower absenteeism, which can result in increased productivity.

The best place to start in developing such a program is by performing an in-depth evaluation of your organization's employees' health status and target specific areas of concern. Wellness programs can include health risk assessments, screenings, health fairs, speakers' bureaus, health handbooks, smoking cessation pro-grams, weight loss programs, massage therapy, health information centers, and fitness programs/facilities. The goal is to assist employees in safely and effectively improving their health; encouraging healthy, active lifestyles; and reducing preventable illnesses and injuries.

Monitoring vendor performance

Another way to control healthcare costs is by becoming smarter about purchasing healthcare plans. One approach is to aggressively engage healthcare plan vendors in the effort to control costs by asking them what they are doing to help take costs out of the system. Some companies are borrowing best practices from their purchasing departments and applying them to healthcare purchases. Others are encouraging their healthcare insurers to use process improvement tools to enhance their own systems and reduce costs.

Larger companies routinely use quality indicators to choose their healthcare plans, an approach small-to-medium-sized employers could also consider. Such quality indicators include access to care, ability to see specialists or use an emergency room while out of town, rate of mammography screening, coverage of specific clinical treatments, responsiveness to members' complaints, and consumer satisfaction.

Do a health plan checkup

Using the power of the Internet, implementing well-ness programs, and monitoring vendor performance may not be enough to get at the root of escalating health insurance costs. With the competition for good employees so intense, employers may decide to absorb the costs. However, being aware of the options and knowing how to judge which plan is right for your company can be a step in the right direction. For more information about healthcare plan options and reducing costs, contact CFG Insurance Services at 952.945.0200, or email CFG at info@cfginsurance.com.

CFG Update March/April 2001
Continue to Next Article

Kahler, Pam

From: Fiocchi, Tim
Sent: Tuesday, February 19, 2002 12:40 PM
To: Kahler, Pam
Subject: RE: Drafting Instructions

EXCELLENT! Thanks, I really needed some good news today. I was looking at 40.98 (1)(d). Forget number 3 then.

-----Original Message-----
From: Kahler, Pam
Sent: Tuesday, February 19, 2002 12:35 PM
To: Fiocchi, Tim
Subject: RE: Drafting Instructions

Tim:

I think what you were looking for in the budget is there. See the change to s. 40.98 (5). It is renumbered to 40.98 (5) (am) and then 40.98 (5) (bm) is created to allow the dept. and bd. to limit the guaranted issue to that required under s. 635.19. The intention was that the guaranteed issue would only apply to small employers, with the conditions and exceptions that are included in s. 635.19.

Pam

-----Original Message-----
From: Fiocchi, Tim
Sent: Tuesday, February 19, 2002 12:12 PM
To: Kahler, Pam; Champagne, Rick
Cc: Dake, Brian
Subject: Drafting Instructions

Pam and Rick,

Brian Dake asked me to send you drafting instructions for the portion of the omnibus health care bill that the Speaker's working group asked for that relates to the Private Employer Health Care Coverage Program. Below you will find these instructions.
It was my impression that the changes contained in number 3 had been included in Act 16, but apparently I was wrong. If you have questions please call me at 6-3780.

1. Create, and provide funding from the OCI surplus, for a loan to the Private Employer Health Care Coverage Program (PEHCCP) in the amount of $850,000 for operating costs.
2. Give DETF authority to solicit, accept, and spend funds from private sources for the PEHCCP.
3. Limiting additional "Guaranteed Issue":

The language included in Act 9 expanded the eligibility currently required under the federal HIPPA law which provides guaranteed issue to groups of 2-50 to include groups of 2 to an infinite number, except for a person operating a farm business, in which case the minimum is one employee.

We have been advised that it is highly probable that any expansion of the federal guaranteed issue provision within the pool would result in the insurance companies choosing not to take part in the program at all. Without insurer participation, there is no program. Therefore, we are proposing to give ETF and the Private Employer Health Care Board the discretion to decide whether to retain or delete the expanded guaranteed issue provision currently in the statutes.

Tim Fiocchi

Research Assistant
Representative Lorraine Seratti's Office
Phone: (608) 266-3780
Fax: (608) 282-3636

TELEPHONE DRAFTING INSTRUCTIONS

Drafting instructions received by Debora Kennedy.

DATE: 2/15

CONVERSATION WITH: Rachel Carabell

OF: LFB

TELEPHONE NO: 6-8017

REGARDING LRB # OR DRAFT TOPIC: Smaall Bs. Health Ins. Reform

INSTRUCTIONS: Re Prescrip. Drug Purchasing Consortiums

Authorize DOA to help health care providers + payors (self-insurers, insurers) receive prescrip drugs at reduced costs. Help pharmacies negotiate cheaper prices for drugs — negotiate rebates, plus authorize DOA to organize health care providers to negotiate reduced prices, through direct purchases + rebates. Authorize DOA to work with other states.

DOA to submit report 1/1/03 identifying participating organizations + strategy will pursue to reduce costs Follow up report 2005 to identify status or implementation (successes or failures) (financ + approp. standing committee + governor)

Brian Dake 2-22

changes to funding

for ETF private employer program, make the $850,000 loan from s. 20.145 (1)(g)

For small employer Cat. Care program, take $500,000 from s. 20.145(1)(g) instead of GPR

per Sandy Lonergan in answer to questions:

have small employers ~~that have employees~~ that have employees in Cat. Care program pay the additional premium, not all small employers

per Sandy Lovejoy

Jan 1, 2003

beginning date of ~~the~~ 5-year pilot ↗

person "applies" for cov under HIRSP —
are they subject to elig
req under HIRSP?
(other than "eligible for cov
under an emp policy)

if in automatically,
what happens at
end of 5 yrs)

pilot
operates
in "region" → small employer located
~~person resides~~
~~entity~~

based on

~~[redacted]~~ OCI do provide discount

HIRSP bd may waive elig req for person
who applies

Cat bd address ~~issue~~ of person's elig for
HIRSP if covered,
at end of 5 yrs

Kahler, Pam

From: Sandy Lonergan and Steve Schumacher [sandyandsteve@charter.net]
Sent: Saturday, February 23, 2002 8:52 AM
To: Pam.Kahler@legis.state.wi.us
Cc: Brian.Dake@legis.state.wi.us; Sandy (W)
Subject: Sandy from Underheim's office from home
Importance: High

Hi Lovely Pam,
It's Saturday morning & I just spoke w/Gregg who just spoke w/Jensen. Go ahead & put the IER clean up & PPOs POS language in the small biz insurance package. If it becomes a problem later on, we will take it out. It's a no on the 2-50 provision though. We'll try & deal with that one later.

If you have any questions, I'm at home but feel free to call me at 837-4650. Thanks again for everything.
Sandy

Kahler, Pam

From: Lonergan, Sandra
Sent: Monday, February 25, 2002 11:59 AM
To: Kahler, Pam
Cc: Sweet, Richard
Subject: FW: IER
Importance: High

Hi Pam--
Someone discovered a problem w/the IER clean up language -- Here is Carol Rubin's suggestion for "fixing" it. Does this make sense to you? I'm asking Dick to look at it also --
thanks,
Sandy

-----Original Message-----
From: CRubin@weatrust.com [mailto:CRubin@weatrust.com]
Sent: Monday, February 25, 2002 11:37 AM
To: Lonergan, Sandra
Subject: RE: IER
Importance: High

Sandy, Dan Schwartzer just called me and unfortunately I think he has a valid point in that the draft appars to go farther than we or any of the insurers were asking in arguably not requiring the full notice upon disposition of a greivance. I believe everyone is willing to give the full notice, with the list of IRO's, with the letter informing insureds of the disposition of their grievance. We had that in our drafts, and for some reason, Pam Kahler didn't include it, and it looks like nobody caught it including me or Barbara Zabawa until today. I don't think we can just ignore and interpret this the way we all intended it since it could damage the trust the affected parties have built up working together on this.

Fortunately,I think there is any easy fix. Revise 632.835(2)(bg) to say:

(bg) An insurer is not required to provide the notice under par. (b) until it sends its notice of disposition of the internal grievance if all of the following apply:

. . .

I should be in my office all day if I can assist in sorting this out.

01-4956

P.L. 106-554 —— MSA

Marcy Mock → Tom Retzlaff DOR

7-5023

community renewal & new markets act

archer medical savings accounts under
§ 26 USC 220

-4956

Marcy Stock -- 2/25/02

MSAs aren't working because the IRC update hasn't been adopted

PL 106-554 extended MSA → 2002

Brian Dake says to call Sara in Urban's office 6-9175 Sarah - Urban rep.

create a deduction for MSAs

1) require the state to adopt any changes

2) adopt an MSA plan that will apply only if there is no federal plan

State of Wisconsin
2001 – 2002 LEGISLATURE

LRB–4956/1
PJK,RAC,DAK,MES:...

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** a loan from the general fund for the private employer health care coverage program, small employer health insurance rates, requiring the group insurance board to offer an additional health insurance plan for state employees, providing exemptions from emergency rule procedures, 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 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 health insurance rates

Under current law, the rates that insurers may charge for health insurance provided to employers that have between two and 50 employees (small employers) are regulated to the extent that rates charged to small employers with similar case

characteristics for the same or similar benefits may not vary from the midpoint rate for those small employers by more than 35% of the midpoint rate. Case characteristics include such characteristics of a small employer's employees as age, sex, and geographic location, but do not include health status, occupation, or claim experience. This bill reduces the amount by which rates charged to small employers with similar case characteristics for the same or similar benefits may vary from the midpoint rate to 30% of the midpoint rate.

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 shall 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 organzations 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% 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 2 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.

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

(END)

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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 in conjunction with associations of health care providers, insurers, or self–insurers that seeks to act 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 $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.

History: 1971 c. 40 s. 93; 1971 c. 125 ss. 51, 52, 53, 54, 55, 522 (1); 1973 c. 117, 333, 336; 1975 c. 37, 39; 1975 c. 147 s. 54; 1975 c. 372 s. 41; 1977 c. 29, 418; 1979 c. 34 ss. 121 to 127, 2102 (26) (a); 1979 c. 109 s. 16; 1979 c. 221, 313; 1981 c. 20 ss. 142m to 145, 2202 (26) (b); 1983 a. 27, 120; 1985 a. 29, 340; 1987 a. 27; 1989 a. 187; 1991 a. 39, 315; 1993 a. 16; 1995 a. 10, 27, 463; 1997 a. 27, 35, 227, 252; 2001 a. 16.

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).

NOTE: NOTE: Par. (g) is repealed eff. 1–1–10 by 1999 Wis. Act 9.NOTE:

History: 1971 c. 40 s. 93; 1971 c. 125; 1973 c. 90, 151, 337; 1975 c. 39; 1977 c. 29, 84; 1979 c. 34, 38; 1979 c. 102 s. 236 (4); 1981 c. 96; 1981 c. 187 s. 10; 1981 c. 250; 1983 a. 27, 247, 255; 1983 a. 394 s. 2; 1985 a. 29; 1987 a. 27, 107; 1987 a. 403 s. 256; 1989 a. 14, 31; 1989 a. 56 s. 259; 1991 a. 269; 1995 a. 27, 88, 89, 240; 1997 a. 26, 27; 1999 a. 9; 2001 a. 16.

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.

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38; s. 13.93 (2) (c).

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), and (4), 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, 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:

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12; 1999 a. 9.

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.~~ pars. (b) and (c), 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.

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; 1999 a. 9, 165; 2001 a. 16.

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. 635.05 (1) of the statutes is amended to read:

635.05 **(1)** Establishing restrictions on premium rates that a small employer insurer may charge a small employer such that the premium rates charged to small employers with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those small employers by more than ~~35%~~ 30% of that midpoint rate.

History: 1991 a. 39, 250; 2001 a. 16.

SECTION 19. 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) (c), 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 sale 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) (b) 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 subd. 1. 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 subd. 1.

(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 20. 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) PROGAM 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 to not 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 to not 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 ~~sale~~ 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 21. 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, for terms expiring on May 1, 2005.

(b) Three members, one nominated by the Wisconsin Association of Life and Health Insurers, 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. auto ref 2 (see p. 22)

(5) RULES RELATED TO SMALL EMPLOYER HEALTH INSURANCE RATES. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may promulgate the rules required under section 635.05 (1) of the statutes, as affected by this act, for the period before the effective date of the permanent rules required under section 635.05 (1) of the statutes, as affected 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.

(6) 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 22. 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 23. Initial applicability.

auto ref 3 (see ins 22-6)

(1) SMALL EMPLOYER HEALTH INSURANCE RATES. The treatment of section 635.05 (1) of the statutes and SECTION NO TAG (3) of this act first apply to rates charged under policies or plans issued or renewed to small employers on September 1, 2002.

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

(1) SMALL EMPLOYER HEALTH INSURANCE RATES. The treatment of section 635.05 (1) of the statutes takes effect on September 1, 2002.

(END of "most of bill")

insert 22-3

insert 22-4

insert 22-8

insert 22-7

auto ref 1 (p.18)

auto ref 2 (p.20)

INSERT R–1

AN ACT ...; ~~relating to:~~ 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, eliminating the requirement that an employer offering a preferred provider plan also offer a point–of–service option plan, providing notice of the right to independent review, granting rule–making authority,

(END OF INSERT R–1)

requiring reports,

authorizing assistance in negotiating prescription drug rebates and reducing prescription drug charges,

1995 Assembly Bill 545

Date of enactment: **June 26, 1996**
Date of publication*: **July 10, 1996**

1995 WISCONSIN ACT 453

AN ACT *to repeal* 632.745 (1) (f) 2., *to renumber* 635.02 (5m), and *to create* 71.05 (6) (a) 19., 71.05 (6) (b) 22., 71.07 (5) (a) 7., 71.10 (4) (j), 71.83 (1) (c), 632.745 (1) (f) 2., 632.898 and 635.02 (5m) (b) of the statutes; **relating to:** tax–exempt individual employe medical savings accounts established by employers or self–employed persons with the difference between the cost of low–cost, high cost–share health care coverage and more costly health care coverage, excluding coverage that is linked to a medical savings account from certain coverage portability provisions, and granting rule–making authority.

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

SECTION 1. 71.05 (6) (a) 19. of the statutes is created to read:

71.05 (6) (a) 19. Any principal that is withdrawn, and any accumulated interest, dividends or other gain that accrues, from an account described under s. 632.898 during the taxable year in which a withdrawal occurs from such an account if any amount of the money or other assets in the account is withdrawn for any reason other than the payment of medical care expenses or long–term care expenses or the purchase of long–term care insurance, as defined in s. 146.91 (1), for the account holder, his or her spouse and all nonspouse dependents, as defined in s. 632.898 (1) (b), except that this subdivision does not apply after the death of the account holder.

SECTION 2. 71.05 (6) (b) 22. of the statutes is created to read:

71.05 (6) (b) 22. Any amount that is deposited by an employer on behalf of that employer's employe, or by a self–employed person on his or her own behalf, in an account described under s. 632.898, up to $2,000 each year for an individual, up to $2,000 each year for his or her spouse and up to $1,000 each year for each nonspouse dependent, as defined in s. 632.898 (1) (b), and any interest, dividends or other gain that accrues in the account if the interest, dividends or other gain is redeposited in the account, if the account is used exclusively to pay the medical care expenses and long–term care expenses of the individual, his or her spouse and each minor dependent or to purchase long–term care insurance, as defined in s. 146.91 (1), for such individuals. The maximum amount of a deposit to an account that is created under this subdivision shall be increased each year, beginning in 1998, by a percentage equal to the percentage change between the U.S. consumer price index for all urban consumers, U.S. city average, for the month of June of the current year and the U.S. consumer price index for all urban consumers, U.S. city average, for the month of June of the previous year, as determined by the U.S. department of labor. The revised amounts shall be rounded to the nearest whole number. The department of revenue shall adopt by rule the changes in dollar amounts required under this subdivision every year and incorporate the changes in the income tax forms and instructions.

* Section 991.11, Wisconsin Statutes 1993–94: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

(2) (b) and 71.45 (2) (a) 13. b. of the statutes; **relating to:** references to the Internal Revenue Code for income and franchise tax purposes.

~~Analysis by the Legislative Reference Bureau~~

This bill adopts, for income tax and franchise tax purposes, the changes to the federal Internal Revenue Code made by Public Laws ~~106–206, 106–230, 106–519,~~ 106–554, ~~106–573, 107–15, 107–16,~~ excluding the section related to a deduction for higher education expenses, and ~~107–22~~.

~~This bill will be referred to the joint survey committee on tax exemptions for a detailed analysis, which will be printed as an appendix to this bill.~~

~~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. 71.01 (6) (g) of the statutes is repealed.

SECTION 2. 71.01 (6) (h) of the statutes is repealed.

SECTION 3. 71.01 (6) (i) of the statutes is amended to read:

71.01 **(6)** (i) For taxable years that begin after December 31, 1993, and before January 1, 1995, for natural persons and fiduciaries, except fiduciaries of nuclear decommissioning trust or reserve funds, "Internal Revenue Code" means the federal Internal Revenue Code as amended to December 31, 1993, excluding sections 103, 104, and 110 of P.L. 102–227 and sections 13113, 13150 (d), 13171 (d), 13174, 13203 (d), and 13215 of P.L. 103–66 and as amended by P.L. 103–296, P.L. 103–337, P.L. 103–465, P.L. 104–7, excluding section 1 of P.L. 104–7, P.L. 104–188, excluding section 1311 of P.L. 104–188, P.L. 104–191, P.L. 104–193, P.L. 105–34, P.L. 105–206 and, P.L. 105–277, and P.L. 106–554, and as indirectly affected by P.L. 99–514, P.L. 100–203, P.L. 100–647, P.L. 101–73, P.L. 101–140, P.L. 101–179, P.L. 101–239, P.L. 101–280, P.L. 101–508, P.L. 102–90, P.L. 102–227, excluding sections 103, 104, and