State of Wisconsin
2001 – 2002 LEGISLATURE

January 2002 Special Session

LRBb2413/
PJK/RAC/DK/MS/JK:cjs:pg

LFB:......Jakel (CM) – Small business health insurance reform

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO ASSEMBLY BILL 1

1 At the locations indicated, amend the substitute amendment as follows:

2 **1.** Page 10, line 8: after that line insert:

3 "**SECTION 14j.** 15.735 of the statutes is created to read:

4 **15.735 Same; attached boards. (1)** SMALL EMPLOYER CATASTROPHIC
5 REINSURANCE BOARD. (a) There is created a small employer catastrophic reinsurance
6 board that is attached to the office of the commissioner of insurance under s. 15.03.
7 The board shall consist of the commissioner of insurance and the following members:

8 1. Two members who represent small employers, as defined in s. 635.02 (7), and
9 who are selected from a list of nominees submitted by organizations representing
10 small businesses.

1 2. Four members who represent small employer insurers, as defined in s.
2 635.02 (8), and who are selected from a list of nominees submitted by organizations
3 representing health insurers.
4 3. One member who is a physician, as defined in s. 448.01 (5), and who is
5 selected from a list of nominees submitted by organizations representing physicians.
6 4. One member who is a nurse, as defined in s. 441.11 (2), who works in an
7 executive position, and who is selected from a list of nominees submitted by
8 organizations representing nurses.
9 5. Two members who represent hospitals, including one member from a rural
10 hospital and one member from an urban hospital, and who are selected from a list
11 of nominees submitted by organizations representing hospitals.
12 (b) The members under par. (a) 1. to 5. shall be appointed for 3–year terms. Any
13 such member may be removed by the governor for just cause.".
14 **2.** Page 11, line 9: after that line insert:
15 "SECTION 21e. 16.735 of the statutes is created to read:
16 **16.735 Negotiations for purchase of prescription drugs; rebates. (1)**
17 In this section:
18 (a) "Health care provider" has the meaning given in s. 146.81 (1).
19 (b) "Insurer" has the meaning given in s. 632.745 (15).
20 (c) "Labeler" means a person that receives prescription drugs from a
21 manufacturer or wholesaler, repackages the prescription drugs for later retail sale,
22 and has a labeler code issued by the federal food and drug administration under 21
23 CFR 207.20 (b).

1 (d) "Manufacturer" means a manufacturer of prescription drugs and includes
2 a subsidiary or affiliate of the manufacturer.
3 (e) "Pharmacist" has the meaning given in s. 450.01 (15).
4 (f) "Prescription drug" has the meaning given in s. 450.01 (20).
5 (g) "Self–insurer" means an employer or labor organization acting solely or
6 acting jointly with a labor organization or an employer to provide employee health
7 care benefits on a self–insured basis.
8 **(2)** The department or an entity with which the department contracts may do
9 all of the following:
10 (a) Assist a health care provider, insurer, or self–insurer that acts in this state
11 or that seeks to act in conjunction with associations of health care providers,
12 insurers, or self–insurers in states other than this state to negotiate rebate
13 agreements with manufacturers or labelers for prescription drugs that are produced
14 by the manufacturers or repackaged by the labelers and are sold for prescribed use.
15 (b) Assist a health care provider, insurer, or self–insurer to develop an in–state
16 purchasing group or, in conjunction with associations of health care providers,
17 insurers, or self–insurers in states other than this state, a multistate purchasing
18 group, for the direct negotiation with prescription drug manufacturers and labelers
19 of reduced charges for prescription drugs that are produced by the manufacturers or
20 repackaged by the labelers and are sold for prescribed use.".
21 **3.** Page 13, line 13: after that line insert:
22 "**SECTION 30c.** 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).".

4. Page 19, line 20: after that line insert:

"**SECTION 52im.** 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).".

5. Page 32, line 23: after that line insert:

"**SECTION 100hp.** 40.51 (6) of the statutes is renumbered 40.51 (6) (a) and amended to read:

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

SECTION 100hr. 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,

1 deductibles, and co–payments and to select the hospital and medical benefits offered
2 under the plan, but only if the group insurance board determines that such a defined
3 contribution plan is available in the area of the place of employment and approves
4 the plan.

5 SECTION **100ic.** 40.98 (2) (h) of the statutes is created to read:

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

12 SECTION **100ix.** 40.98 (6m) of the statutes is created to read:

13 40.98 **(6m)** The secretary of administration shall lapse from the appropriation
14 under s. 20.515 (2) (g) to the general fund the amounts necessary to repay the loan
15 under s. 601.34 when the secretary of administration, after consulting with the
16 board, determines that funds in the appropriation under s. 20.515 (2) (g) are
17 sufficient to make the lapse. The amounts that are required to be lapsed under s.
18 20.515 (2) (g) shall equal the amount necessary to pay all principal and interest costs
19 on the loan, less any amount that is lapsed to the general fund under s. 20.515 (2)
20 (a) at the end of the 2001–03 fiscal biennium. The secretary of administration may
21 lapse the amounts under s. 20.515 (2) (g) in installments.".

22 **6.** Page 62, line 25: after "by" insert "P.L. 106–554 and any subsequent federal
23 law related to Archer medical savings accounts under 26 USC 220,".

1 **7.** Page 63, line 2: after "by" insert "P.L. 106–554 and any subsequent federal
2 law related to Archer medical savings accounts under 26 USC 220,".
3 **8.** Page 63, line 8: after "2001," insert "and as amended by any subsequent
4 federal law related to Archer medical savings accounts under 26 USC 220,".
5 **9.** Page 63, line 19: after "106–554," insert "and any subsequent federal law
6 related to Archer medical savings accounts under 26 USC 220,".
7 **10.** Page 63, line 23: after "2001," insert "except amendments related to
8 Archer medical savings accounts under 26 USC 220,".
9 **11.** Page 66, line 15: after that line insert:
10 "**SECTION 170j.** 71.05 (6) (a) 21. of the statutes is created to read:
11 71.05 **(6)** (a) 21. Any principal that is withdrawn, and any accumulated
12 interest, dividends or other gain that accrues, from an account described under s.
13 632.898 during the taxable year in which a withdrawal occurs from such an account
14 if any amount of the money or other assets in the account is withdrawn for any reason
15 other than the payment of medical care expenses or long–term care expenses for the
16 account holder, his or her spouse and all nonspouse dependents, as defined in s.
17 632.898 (1) (b), except that this subdivision does not apply after the death of the
18 account holder.
19 **SECTION 170m.** 71.05 (6) (b) 34. of the statutes is created to read:
20 71.05 **(6)** (b) 34. Any amount that is deposited by an employer on behalf of that
21 employer's employee, or by a self–employed person on his or her own behalf, in an
22 account described under s. 632.898, up to $2,000 each year for an individual, up to
23 $2,000 each year for his or her spouse and up to $1,000 each year for each nonspouse
24 dependent, as defined in s. 632.898 (1) (b), and any interest, dividends or other gain

1 that accrues in the account if the interest, dividends or other gain is redeposited in
2 the account, if the account is used exclusively to pay the medical care expenses and
3 long–term care expenses of the individual, his or her spouse and each minor
4 dependent. For taxable years beginning after December 31, 2003, the maximum
5 amount of a deposit to an account that is created under this subdivision shall be
6 increased each year by a percentage equal to the percentage change between the U.S.
7 consumer price index for all urban consumers, U.S. city average, for the month of
8 August of the previous year and the U.S. consumer price index for all urban
9 consumers, U.S. city average, for the month of August 2002, as determined by the
10 U.S. department of labor. The revised amounts shall be rounded to the nearest whole
11 number or, if the revised amount is not a whole number and is a multiple of $0.50,
12 such an amount shall be rounded to the next higher whole number. The department
13 of revenue shall adopt by rule the changes in dollar amounts required under this
14 subdivision every year, and incorporate the changes in the income tax forms and
15 instructions.

16 **Section 170p.** 71.07 (5) (a) 9. of the statutes is created to read:

17 71.07 (5) (a) 9. The amount claimed as a deduction for unreimbursed medical
18 care expenses under section 213 (a) of the Internal Revenue Code to the extent that
19 the funds used to pay for the unreimbursed expenses for which the deduction was
20 claimed were withdrawn from an account described under s. 71.05 (6) (b) 34.".

21 **12.** Page 76, line 1: on lines 1 and 3, after "by" insert "P.L. 106–554 and any
22 subsequent federal law related to Archer medical savings accounts under 26 USC
23 220,".

1 **13.** Page 76, line 9: after "2001," insert "and as amended by any subsequent
2 federal law related to Archer medical savings accounts under 26 USC 220,".

3 **14.** Page 76, line 22: after "106–554," insert "and any subsequent federal law
4 related to Archer medical savings accounts under 26 USC 220,".

5 **15.** Page 77, line 1: after "2001," insert "except amendments related to Archer
6 medical savings accounts under 26 USC 220,".

7 **16.** Page 85, line 25: after "by" insert "P.L. 106–554 and any subsequent
8 federal law related to Archer medical savings accounts under 26 USC 220,".

9 **17.** Page 86, line 2: after "by" insert "P.L. 106–554 and any subsequent federal
10 law related to Archer medical savings accounts under 26 USC 220,".

11 **18.** Page 86, line 8: after "2001," insert "and as amended by any subsequent
12 federal law related to Archer medical savings accounts under 26 USC 220,".

13 **19.** Page 86, line 19: after "106–554," insert "and any subsequent federal law
14 related to Archer medical savings accounts under 26 USC 220,".

15 **20.** Page 86, line 22: after "2001," insert "except amendments related to
16 Archer medical savings accounts under 26 USC 220,".

17 **21.** Page 110, line 12: on lines 12 and 14, after "by" insert "P.L. 106–554 and
18 any subsequent federal law related to Archer medical savings accounts under 26
19 USC 220,".

20 **22.** Page 110, line 22: after "2001," insert "and as amended by any subsequent
21 federal law related to Archer medical savings accounts under 26 USC 220,".

22 **23.** Page 111, line 8: after "106–554," insert "and any subsequent federal law
23 related to Archer medical savings accounts under 26 USC 220,".

1 **24.** Page 111, line 14: after "2001," insert "and as amended by any subsequent
2 federal law related to Archer medical savings accounts under 26 USC 220,".
3 **25.** Page 111, line 25: after "106–554," insert "and any subsequent federal law
4 related to Archer medical savings accounts under 26 USC 220,".
5 **26.** Page 112, line 9: after "2001," insert "and as amended by any subsequent
6 federal law related to Archer medical savings accounts under 26 USC 220,".
7 **27.** Page 112, line 20: after "106–554," insert "and any subsequent federal law
8 related to Archer medical savings accounts under 26 USC 220,".
9 **28.** Page 112, line 23: after "2001," insert "except amendments related to
10 Archer medical savings accounts under 26 USC 220,".
11 **29.** Page 123, line 11: on lines 11 and 13, after "by" insert "P.L. 106–554 and
12 any subsequent federal law related to Archer medical savings accounts under 26
13 USC 220,".
14 **30.** Page 123, line 19: after "2001," insert "and as amended by any subsequent
15 federal law related to Archer medical savings accounts under 26 USC 220,".
16 **31.** Page 124, line 7: after "106–554," insert "and any subsequent federal law
17 related to Archer medical savings accounts under 26 USC 220,".
18 **32.** Page 124, line 12: after "2001," insert "except amendments related to
19 Archer medical savings accounts under 26 USC 220,".
20 **33.** Page 134, line 10: on lines 10 and 12, after "by" insert "P.L. 106–554 and
21 any subsequent federal law related to Archer medical savings accounts under 26
22 USC 220,".

1 **34.** Page 134, line 18: after "2001," insert "and as amended by any subsequent
2 federal law related to Archer medical savings accounts under 26 USC 220,".
3 **35.** Page 135, line 3: after "106–554," insert "and any subsequent federal law
4 related to Archer medical savings accounts under 26 USC 220,".
5 **36.** Page 135, line 8: after "2001," insert "except amendments related to
6 Archer medical savings accounts under 26 USC 220,".
7 **37.** Page 138, line 9: after that line insert:
8 "SECTION **231v.** 71.83 (1) (c) of the statutes is renumbered 71.83 (1) (c) 1.
9 SECTION **231ve.** 71.83 (1) (c) 2. and 3. of the statutes are created to read:
10 71.83 (1) (c) 2. Except as provided in subd. 3., if a person is required to add any
11 amount to federal adjusted gross income under s. 71.05 (6) (a) 21., the person shall
12 pay an amount equal to 10% of the amount that is withdrawn from the account that
13 results in a person making a payment under s. 71.05 (6) (a) 21.
14 3. The penalty under subd. 2. does not apply and up to 25% of the balance in
15 the account described under s. 632.898 may be withdrawn each year if any of the
16 following occurs:
17 a. The account holder or his or her spouse reaches the age of 59.5 years during
18 the year in which the withdrawal occurs.
19 b. The balance in the account exceeds $100,000.".
20 **38.** Page 172, line 10: after that line insert:
21 "SECTION **336d.** 146.96 of the statutes is created to read:
22 **146.96 Uniform claim processing form.** Beginning no later than July 1,
23 2004, every health care provider, as defined in s. 146.81 (1), shall use the uniform

1 claim processing form developed by the commissioner of insurance under s. 601.41
2 (9) (b) when submitting a claim to an insurer.".

3 **39.** Page 221, line 13: after that line insert:

4 "SECTION **508r.** 601.34 of the statutes is created to read:

5 **601.34 Loan to general fund.** No later than the first day of the 2nd month
6 after the effective date of this section .... [revisor inserts date], an amount equal to
7 $850,000 shall be lapsed from the appropriation account under s. 20.145 (1) (g) to the
8 general fund. The amount lapsed from the appropriation account shall be considered
9 a loan to the general fund and interest shall accrue on the amount lapsed at the
10 average rate earned by the state on its deposits in the state investment fund during
11 the period of the loan. The general fund shall repay the loan from moneys lapsed to
12 the general fund from the appropriation under s. 20.515 (2) (a) at the end of the
13 2001–03 fiscal biennium, if any, and from moneys lapsed to the general fund from the
14 appropriation under s. 20.515 (2) (g) in the amounts specified in s. 40.98 (6m). If the
15 secretary of administration determines that the moneys lapsed from these
16 appropriations will not be sufficient to repay the loan within a reasonable period of
17 time, as determined by the secretary and the commissioner, the secretary shall credit
18 the appropriation account under s. 20.145 (1) (g) from moneys in the general fund an
19 amount sufficient to repay the loan.

20 SECTION **508s.** 601.41 (8) of the statutes is created to read:

21 601.41 **(8)** UNIFORM EMPLOYEE APPLICATION FORM. (a) In this subsection:

22 1. "Group health benefit plan" has the meaning given in s. 632.745 (9).

23 2. "Small employer" has the meaning given in s. 635.02 (7).

24 3. "Small employer insurer" has the meaning given in s. 635.02 (8).

1 (b) In consultation with the life and disability advisory council established by
2 the commissioner, the commissioner shall by rule develop a uniform employee
3 application form that a small employer insurer must use when a small employer
4 applies for coverage under a group health benefit plan offered by the small employer
5 insurer. The commissioner shall revise the form at least every 2 years.

6 **SECTION 508t.** 601.41 (9) of the statutes is created to read:

7 601.41 **(9)** UNIFORM CLAIM PROCESSING FORM. (a) In this subsection, "health care
8 provider" has the meaning given in s. 146.81 (1).

9 (b) If the federal government has not developed by July 1, 2003, a uniform claim
10 processing form that must be used by all health care providers for submitting claims
11 to insurers and by all insurers for processing claims submitted by health care
12 providers, the commissioner shall develop, by no later than December 31, 2003, a
13 uniform claim processing form for that purpose.".

14 **40.** Page 221, line 22: after that line insert:

15 "**SECTION 509cm.** 610.65 of the statutes is created to read:

16 **610.65 Uniform claim processing form.** Beginning no later than July 1,
17 2004, every insurer shall use the uniform claim processing form developed by the
18 commissioner under s. 601.41 (9) (b) when processing a claim submitted by a health
19 care provider, as defined in s. 146.81 (1).".

20 **41.** Page 221, line 25: after that line insert:

21 "**SECTION 509gc.** 632.835 (2) (b) of the statutes, as created by 1999 Wisconsin
22 Act 155, is amended to read:

23 632.835 **(2)** (b) ~~Whenever~~ <u>If</u> an adverse determination or an experimental
24 treatment determination is made, the insurer involved in the determination shall

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

7 **SECTION 509gd.** 632.835 (2) (bg) of the statutes is created to read:

8 632.835 **(2)** (bg) Notwithstanding par. (b), an insurer is not required to provide
9 the notice under par. (b) to an insured until the insurer sends notice of the disposition
10 of the internal grievance, if all of the following apply:

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

16 2. The insurer includes on its explanation of benefits form a statement that the
17 insured may have a right to an independent review after the internal grievance
18 process and that an insured may be entitled to expedited independent review with
19 respect to an urgent matter. The statement shall also include a reference to the
20 section of the policy or certificate that contains the description of the independent
21 review procedure as required under subd. 1. The statement shall provide a toll–free
22 telephone number and website, if appropriate, where consumers may obtain
23 additional information regarding internal grievance and independent review
24 processes.

1 3. For any adverse determination or experimental treatment determination for
2 which an explanation of benefits is not provided to the insured, the insurer provides
3 a notice that the insured may have a right to an independent review after the
4 internal grievance process and that an insured may be entitled to expedited,
5 independent review with respect to an urgent matter. The notice shall also include
6 a reference to the section of the policy or certificate that contains the description of
7 the independent review procedure as required under subd. 1. The notice shall
8 provide a toll–free telephone number and website, if appropriate, where consumers
9 may obtain additional information regarding internal grievance and independent
10 review processes.

11 SECTION 509gm. 632.898 of the statutes is created to read:

12 **632.898 Medical savings accounts. (1)** In this section:

13 (a) "Account administrator" means any of the following:

14 1. A financial institution, the accounts of which are insured by the Federal
15 Deposit Insurance Corporation or the national credit union share insurance fund.

16 2. A trust company bank organized under ch. 223.

17 3. An insurer authorized to do business in this state.

18 4. A broker–dealer licensed under subch. III of ch. 551.

19 5. A plan administrator licensed under ch. 633.

20 6. A certified public accountant licensed to practice in this state.

21 7. An employer that has a self–insured health plan.

22 8. An employer that participates in the program under this section.

23 (b) "High cost–share health plan" means any health insurance policy,
24 certificate, or contract with deductibles, copayments, or other cost–sharing

delete pp. 15 – 17

1 provisions of at least $1,500 if the insured's coverage is single or at least $3,000 if the
2 insured's coverage is family.
3 **(2)** (a) An employer that, in providing health insurance coverage for its
4 employees, offers its employees a choice of health benefit plan options that includes
5 a high cost–share health plan may establish a medical savings account for an
6 employee who chooses a high cost–share health plan.
7 (b) The medical savings account shall be established as a separate account in
8 the employee's name and shall be the employee's property. The account may be
9 established with any account administrator that is approved by the commissioner to
10 administer medical savings accounts. The commissioner shall approve an account
11 administrator to administer medical savings accounts if the account administrator
12 insures the principal of the medical savings account against loss from any cause,
13 including loss due to market fluctuation. Whenever an employer establishes a
14 medical savings account on behalf of an employee, the employer shall notify the
15 department of revenue, in the manner prescribed by the department of revenue, of
16 the establishment of the account, the employee's name and social security number,
17 the name and address of the account administrator, and any other information that
18 the department of revenue may require.
19 (c) Only an employer under par. (a), whether that employer established the
20 account or is a succeeding employer of an employee for whom a medical savings
21 account has been established, may make deposits in the medical savings account of
22 an employee who chooses a high cost–share health plan. Except as provided in par.
23 (d), such an employer shall deposit in the account the difference between what the
24 employer pays on behalf of the employee, or the employee and his or her dependents,
25 for the high cost–share health plan and what the employer would pay on behalf of

1 the employee, or the employee and his or her dependents, for the most expensive
2 health benefit plan that the employer offers that is not a high cost–share health plan.
3 Except as provided in sub. (4) (a), no other deposits may be made in the account.

4 (d) An employer that establishes a medical savings account on behalf of an
5 employee is not required to deposit in the account more than $2,000 per year for the
6 employee if the employee's coverage is single, or more than $2,000 per year for the
7 employee, $2,000 per year for the employee's spouse or $1,000 per year for each
8 nonspouse dependent of the employee if the employee's coverage is family. Beginning
9 in 1998, the amounts specified in this paragraph shall be increased each year in the
10 manner provided in s. 71.05 (6) (b) 34.

11 (e) An employee who chooses a high cost–share health plan and for whom a
12 medical savings account is established is not eligible for coverage under a different
13 health benefit plan offered by the employer before the end of the policy term of the
14 high cost–share health plan.

15 **(3)** (a) A self–employed person who purchases a high cost–share health plan
16 may establish a medical savings account in his or her name. Upon establishing a
17 medical savings account, a self–employed person shall notify the department of
18 revenue, in the manner prescribed by the department of revenue, of the
19 establishment of the account, the self–employed person's name and social security
20 number, the name and address of the account administrator, and any other
21 information that the department of revenue may require.

22 (b) Except as provided in par. (c), a self–employed person who establishes a
23 medical savings account shall deposit in the account the difference between what the
24 self–employed person pays for the high cost–share health plan, including coverage
25 for his or her dependents, and what the self–employed person would pay for a more

1 expensive health benefit plan, including coverage for his or her dependents. Except
2 as provided in sub. (4) (b), no other deposits may be made in the account.
3 (c) A self–employed person who establishes a medical savings account is not
4 required to deposit in the account more than $2,000 per year for himself or herself
5 if the self–employed person's coverage is single, or more than $2,000 per year for
6 himself or herself, $2,000 per year for his or her spouse, or $1,000 per year for each
7 nonspouse dependent if the self–employed person's coverage is family. Beginning in
8 1998, the amounts specified in this paragraph shall be increased each year in the
9 manner provided in s. 71.05 (6) (b) 34.
10 **(4)** (a) If an employee with a medical savings account under this section
11 becomes self–employed and purchases a high cost–share health plan, he or she may
12 make deposits in the account as provided in sub. (3).
13 (b) If a self–employed person with a medical savings account under this section
14 becomes employed by an employer described in sub. (2) (a) and chooses a high
15 cost–share health plan, the employer may make deposits in the account as provided
16 in sub. (2).
17 **(5)** (a) Amounts deposited in an account under this section and any interest,
18 dividends or other gain that accrues on amounts deposited in the account may be
19 used only for any of the following:
20 1. To pay expenses for medical care, as defined in 26 USC 213 (d) (1) and as
21 limited in 26 USC 213 (b), including amounts treated as paid for medical care under
22 26 USC 213 (d) (2).
23 2. To pay long–term care expenses of the employee or self–employed person or
24 any of the employee's or self–employed person's dependents.

1 3. To purchase a long–term care insurance policy for the employee or
2 self–employed person or any of the employee's or self–employed person's dependents.
3 (b) An employee or self–employed person with a medical savings account shall
4 provide information about the use of the account funds, in the manner prescribed by
5 the department of revenue, in conjunction with the filing of his or her Wisconsin
6 income tax return.
7 (c) Paragraph (a) does not apply after the death of the employee or
8 self–employed person.
9 **(6)** (a) A person that provides medical care, long–term care, or a long–term care
10 insurance policy, the cost of which is to be paid with funds in a medical savings
11 account, shall bill the employee or self–employed person who is the holder of the
12 account directly, rather than billing the account administrator of the medical savings
13 account.
14 (b) The account administrator of a medical savings account shall do all of the
15 following:
16 1. Permit withdrawals from the account at least once a month.
17 2. Issue an account statement to the holder of the account at least quarterly.
18 **SECTION 509jm.** 635.10 of the statutes is created to read:
19 **635.10 Uniform employee application.** Beginning no later than the first
20 day of the 13th month beginning after the effective date of this section .... [revisor
21 inserts date], every small employer insurer shall use the uniform employee
22 application form developed by the commissioner by rule under s. 601.41 (8) (b) when
23 a small employer applies for coverage under a group health benefit plan offered by
24 the small employer insurer.
25 **SECTION 509mp.** 635.25 of the statutes is created to read:

1 **635.25 Catastrophic risk. (1)** DEFINITION. In this section, "board" means the
2 small employer catastrophic reinsurance board.
3 **(2)** THRESHOLDS FOR COVERED BENEFITS. (a) By December 1, 2002, and every 2
4 years thereafter until December 1, 2006, every small employer insurer that chooses
5 to participate in the program under this section shall select, and submit a report to
6 the commissioner that specifies, the small employer insurer's threshold level of
7 covered benefits, which may be any of the following:
8 1. Fifty thousand dollars in a calendar year.
9 2. One hundred thousand dollars in a calendar year.
10 3. One hundred fifty thousand dollars in a calendar year.
11 4. Two hundred fifty thousand dollars in a calendar year.
12 (b) The threshold level of benefits specified in a report under par. (a) shall apply
13 to each insured under every group health benefit plan issued to a small employer in
14 this state by the small employer insurer submitting the report. In addition, the small
15 employer insurer may in the report limit the covered benefits to which the threshold
16 level applies, which may be costs of one or more types of health care facilities, as
17 defined in s. 146.997 (1) (c), costs of one or more types of health care professionals,
18 as defined in s. 180.1901 (1m), or any combination of those costs.
19 (c) For each of the 2 calendar years after the year in which a small employer
20 insurer submits a report under par. (a), if the amount of applicable covered benefits
21 paid in a calendar year, beginning with 2003 and ending with 2007, by the small
22 employer insurer on behalf of any insured under any group health benefit plan to
23 which this section applies exceeds the threshold level of covered benefits specified in
24 the report, the commissioner, at the direction of the board, shall reimburse the small
25 employer insurer from the appropriation under s. 20.145 (1) (j), in accordance with

1 the procedures established by rule under sub. (5) (e), for 80% of the amount paid by
2 the small employer insurer in that calendar year in excess of the threshold level
3 specified in the report.

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

9 (b) By the date specified by rule under sub. (5) (c), a small employer insurer that
10 chooses to participate in the program under this section shall forward to the board
11 the premiums established by rule under sub. (5) (a), in the manner required by rule
12 under sub. (5) (d). The board shall credit all premium amounts received under this
13 paragraph to the appropriation account under s. 20.145 (1) (j).

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

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

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

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

3 **(4)** PROVIDER DISCOUNTS. (a) The commissioner shall promulgate a rule
4 determined by the board that establishes provider discount rates for charges for
5 covered services provided to insureds under group health benefit plans that are
6 issued or renewed to small employers in this state on or between the dates specified
7 by rule under sub. (5) (b). The rule may provide for higher provider discount rates
8 for covered benefits under group health benefit plans that are issued by small
9 employer insurers that specify higher threshold levels under sub. (2) (a). The rule
10 shall provide that a provider's charges for which a small employer insurer seeks
11 reimbursement shall be discounted in the same proportion that the provider's
12 charges bears to the total amount of provider charges for which the small employer
13 insurer seeks reimbursement. The provider discount rates under this paragraph
14 apply only to services for which the commissioner provides reimbursement under
15 sub. (2) (c).

16 (b) Except for copayments, coinsurance, or deductibles required or authorized
17 under a group health benefit plan, a provider of a covered service, drug, or device
18 shall accept as payment in full for the covered service, drug, or device the discounted
19 payment rate under par. (a) and may not bill the insured under the group health
20 benefit plan who receives the service, drug, or device for any amount by which the
21 charge is reduced under par. (a).

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

24 (a) Establish and periodically adjust the premium amounts that must be
25 charged to small employers under sub. (3) (c) 3. by small employer insurers that

1 choose to participate in the program under this section. The premium amounts
2 under sub. (3) (c) 3. shall be based on an actuarily sound charge per covered
3 individual that is calculated to generate sufficient moneys, in conjunction with
4 provider discounts under sub. (4), to cover the reimbursements required under sub.
5 (2) (c).

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

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

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

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

18 **42.** Page 352, line 12: after that line insert:

19 "(9q) PRESCRIPTION DRUG COST REDUCTION; REPORT. (a) By January 1, 2003, the
20 department of administration shall submit a report that identifies all of the
21 following:

22 1. The participation by health care providers, insurers, and self–insurers in
23 negotiating rebate agreements under section 16.735 (2) (a) of the statutes, as created

1 by this act, and in developing in–state or multistate purchasing groups to negotiate
2 reduced charges under section 16.735 (2) (b) of the statutes, as created by this act.
3 2. Strategies that the department of administration proposes to pursue to
4 reduce costs for prescription drugs in this state.
5 (b) By January 1, 2005, the department of administration shall submit a report
6 that specifies the status of implementing section 16.735 of the statutes, as created
7 by this act, including any success or lack of success in reducing costs for prescription
8 drugs in this state.
9 (c) The department of administration shall submit the reports specified in
10 paragraphs (a) and (b) to the legislature in the manner provided under section 13.172
11 (3) of the statutes, to the members of the joint committee on finance, and to the
12 governor.".
13 **43.** Page 358, line 21: after that line insert:
14 "(1q) SMALL EMPLOYER CATASTROPHIC REINSURANCE BOARD. Notwithstanding the
15 length of terms specified for the members of the small employer catastrophic
16 reinsurance board under section 15.735 (1) (b) of the statutes, as created by this act,
17 the initial members shall be appointed for the following terms:
18 (a) One member representing small employers, one member representing
19 small employer insurers, and one member representing hospitals, for terms expiring
20 on May 1, 2005.
21 (b) Two members representing small employer insurers, and the member who
22 is a physician, for terms expiring on May 1, 2006.

1 (c) One member representing small employers, one member representing small
2 employer insurers, one member representing hospitals, and the member who is a
3 nurse, for terms expiring on May 1, 2007.".

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

15 (3q) Uniform employee application form rules. The commissioner of insurance
16 shall submit in proposed form the rules required under section 601.41 (8) (b) of the
17 statutes, as created by this act, to the legislative council staff under section 227.15
18 (1) of the statutes no later than the first day of the 5th month beginning after the
19 effective date of this subsection.".

20 **44.** Page 359, line 1: after that line insert:

21 "(1q) HEALTH INSURANCE COSTS STUDY. The joint legislative council is requested
22 to conduct a study on the rising costs of health insurance. If the joint legislative
23 council conducts the study, it shall report its findings and conclusions to the
24 legislature in the manner provided under section 13.172 (2) of the statutes.".

1 **45.** Page 388, line 16: after that line insert:

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

7 (2r) HIRING FREEZE EXEMPTION. Notwithstanding any action of the governor or
8 the secretary of administration under section 16.505 (3) of the statutes before the
9 effective date of this subsection, the department of employee trust funds may fill 3.5
10 FTE GPR positions that are vacant on the effective date of this subsection, that are
11 authorized to the department under section 16.505 of the statutes, and that are
12 funded from the appropriation under section 20.512 (2) (a) of the statutes.".

13 **46.** Page 437, line 12: after that line insert:

14 "(3q) TAX EXEMPT MEDICAL SAVINGS ACCOUNTS. The treatment of sections 71.05
15 (6) (a) 21. and (b) 34., 71.07 (5) (a) 9., 71.83 (1) (c) and 632.898 of the statutes first
16 applies to taxable years beginning on January 1 of the year in which the secretary
17 of revenue certifies that the federal government does not extend the availability of
18 the Archer medical savings accounts under 26 USC 220.".

19 **47.** Page 446, line 13: after that line insert:

20 "(1q) NOTICE OF INDEPENDENT REVIEW. The treatment of section 632.835 (2) (b)
21 and (bg) of the statutes takes effect on the date stated in the notice published by the
22 commissioner of insurance in the Wisconsin Administrative Register under section
23 632.835 (8) of the statutes.".

24 **(END)**

D. note

to be the new defined contribution plan. Finally, because the new defined contribution plan may reduce the level of benefits, I notwithstood the requirement under s. 40.03 (6) (c) that the benefits may not be reduced.

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Part of this bill incorporates into the definition of "Internal Revenue Code" the changes made by the federal government in P.L. 106-554. The bill also changes the definition of the IRC to include any future changes made by the federal government to "Archer MSAs" under section 220 of title 26 of the United States Code.

As we discussed, the incorporation of unspecified future changes to federal law into the Wisconsin statutes could be challenged as an unconstitutional delegation of legislative authority. Article IV, section 1 of the Wisconsin Constitution states that "The legislative power shall be vested in a senate and assembly." If this bill becomes law, it could be argued that by automatically adopting any future change made by the federal government to Archer MSAs, the legislature is unconstitutionally delegating its legislative power to make laws by allowing an external source, the federal government, to dictate substantive changes to the statutes.

The Wisconsin Supreme Court has made a distinction between the delegation of a fact-finding power, which seems to be OK, and a law-making power, which may not be OK, although Wisconsin courts seem to be increasingly willing to uphold statutes that adopt external material, particularly federal law. See, generally, *State v. Wakeen*, 263 Wis. 401 (1953), *Williams v. Hoffmann*, 66 Wis. 2d 145, 155-56 (1974), *Krueger v. Department of Revenue*, 124 Wis. 2d 453 (1985) and, especially, *Cleaver v. Department of Revenue*, 158 Wis. 2d 734, 742 (1990).

Krueger seems to indicate that state adoption of future federal changes in the definition of "adjusted gross income" is OK, but that holding seems to have been limited by *Cleaver* at 739 and 740. The Court also stated in *Cleaver* that "The legislature quite obviously desires the opportunity to review any changes enacted by Congress before such changes become part of Wisconsin tax law." *Cleaver* at 742.

Although the likelihood, and outcome, of a constitutional challenge to this bill, should it become law, is impossible to predict, I thought that you should be aware of the possibility. Please let me know if you have any questions about this issue.

Also, if created section 71.05 (6) (b) 34. ever applies, the dates that relate to indexing the deduction amounts for inflation should probably be advanced.

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Beam, Laura

From: Beam, Laura
Sent: Wednesday, March 13, 2002 6:29 PM
To: Russell, Faith; Reinhardt, Rob
Subject: LRBb2413 (plus drafters note) attached per drafting request instruction

01b2413/2

01b2413/2dn

Drafter's Note
FROM THE
Legislative Reference Bureau

LRBb2413/2dn
MES&JK:kmg:kjf

March 13, 2002

Part of this amendment incorporates into the definition of "Internal Revenue Code" the changes made by the federal government in P.L. 106–554. The amendment also changes the definition of the IRC to include any future changes made by the federal government to "Archer MSAs" under section 220 of title 26 of the United States Code.

The incorporation of unspecified future changes to federal law into the Wisconsin Statutes could be challenged as an unconstitutional delegation of legislative authority. Article IV, section 1, of the Wisconsin Constitution states that "The legislative power shall be vested in a senate and assembly." If this amendment becomes law, it could be argued that, by automatically adopting any future change made by the federal government to Archer MSAs, the legislature is unconstitutionally delegating its legislative power to make laws by allowing an external source, the federal government, to dictate substantive changes to the statutes.

The Wisconsin Supreme Court has made a distinction between the delegation of a fact–finding power, which seems to be OK, and a law–making power, which may not be OK, although Wisconsin courts seem to be increasingly willing to uphold statutes that adopt external material, particularly federal law. See, generally, *State v. Wakeen*, 263 Wis. 401 (1953), *Williams v. Hoffmann*, 66 Wis. 2d 145, 155–56 (1974), *Krueger v. Department of Revenue*, 124 Wis. 2d 453 (1985) and, especially, *Cleaver v. Department of Revenue*, 158 Wis. 2d 734, 742 (1990).

Krueger seems to indicate that state adoption of future federal changes in the definition of "adjusted gross income" is OK, but that holding seems to have been limited by *Cleaver* at 739 and 740. The Court also stated in *Cleaver* that "The legislature quite obviously desires the opportunity to review any changes enacted by Congress before such changes become part of Wisconsin tax law." *Cleaver* at 742.

Although the likelihood, and outcome, of a constitutional challenge to this amendment, should it become law, is impossible to predict, we thought that you should be aware of the possibility. Please let us know if you have any questions about this issue.

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State of Wisconsin
2001 – 2002 LEGISLATURE LRBb2413/2
PJK/RAC/DK/MS/JK:cjs&kmg:kjf
January 2002 Special Session

LFB:......Jakel (CM) – Small business health insurance reform

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO ASSEMBLY BILL 1

1 At the locations indicated, amend the substitute amendment as follows:

2 **1.** Page 10, line 8: after that line insert:

3 "SECTION **14j.** 15.735 of the statutes is created to read:

4 **15.735 Same; attached boards. (1)** SMALL EMPLOYER CATASTROPHIC
5 REINSURANCE BOARD. (a) There is created a small employer catastrophic reinsurance
6 board that is attached to the office of the commissioner of insurance under s. 15.03.
7 The board shall consist of the commissioner of insurance and the following members:

8 1. Two members who represent small employers, as defined in s. 635.02 (7), and
9 who are selected from a list of nominees submitted by organizations representing
10 small businesses.

1 2. Four members who represent small employer insurers, as defined in s.
2 635.02 (8), and who are selected from a list of nominees submitted by organizations
3 representing health insurers.
4 3. One member who is a physician, as defined in s. 448.01 (5), and who is
5 selected from a list of nominees submitted by organizations representing physicians.
6 4. One member who is a nurse, as defined in s. 441.11 (2), who works in an
7 executive position, and who is selected from a list of nominees submitted by
8 organizations representing nurses.
9 5. Two members who represent hospitals, including one member from a rural
10 hospital and one member from an urban hospital, and who are selected from a list
11 of nominees submitted by organizations representing hospitals.
12 (b) The members under par. (a) 1. to 5. shall be appointed for 3–year terms. Any
13 such member may be removed by the governor for just cause.".
14 **2.** Page 11, line 9: after that line insert:
15 "SECTION 21e. 16.735 of the statutes is created to read:
16 **16.735 Negotiations for purchase of prescription drugs; rebates. (1)**
17 In this section:
18 (a) "Health care provider" has the meaning given in s. 146.81 (1).
19 (b) "Insurer" has the meaning given in s. 632.745 (15).
20 (c) "Labeler" means a person that receives prescription drugs from a
21 manufacturer or wholesaler, repackages the prescription drugs for later retail sale,
22 and has a labeler code issued by the federal food and drug administration under 21
23 CFR 207.20 (b).

1 (d) "Manufacturer" means a manufacturer of prescription drugs and includes
2 a subsidiary or affiliate of the manufacturer.
3 (e) "Pharmacist" has the meaning given in s. 450.01 (15).
4 (f) "Prescription drug" has the meaning given in s. 450.01 (20).
5 (g) "Self–insurer" means an employer or labor organization acting solely or
6 acting jointly with a labor organization or an employer to provide employee health
7 care benefits on a self–insured basis.
8 **(2)** The department or an entity with which the department contracts may do
9 all of the following:
10 (a) Assist a health care provider, insurer, or self–insurer that acts in this state
11 or that seeks to act in conjunction with associations of health care providers,
12 insurers, or self–insurers in states other than this state to negotiate rebate
13 agreements with manufacturers or labelers for prescription drugs that are produced
14 by the manufacturers or repackaged by the labelers and are sold for prescribed use.
15 (b) Assist a health care provider, insurer, or self–insurer to develop an in–state
16 purchasing group or, in conjunction with associations of health care providers,
17 insurers, or self–insurers in states other than this state, a multistate purchasing
18 group, for the direct negotiation with prescription drug manufacturers and labelers
19 of reduced charges for prescription drugs that are produced by the manufacturers or
20 repackaged by the labelers and are sold for prescribed use.".
21 **3.** Page 13, line 13: after that line insert:
22 "**SECTION 30c.** 20.145 (1) (j) of the statutes is created to read:

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

4 **4.** Page 19, line 20: after that line insert:

5 "SECTION **52im.** 20.515 (2) (g) of the statutes is amended to read:

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

12 **5.** Page 32, line 23: after that line insert:

13 "SECTION **100hp.** 40.51 (6) of the statutes is renumbered 40.51 (6) (a) and
14 amended to read:

15 40.51 **(6)** (a) ~~This~~ Except as provided in par. (b), the state shall offer to all of
16 its employees at least 2 insured or uninsured health care coverage plans providing
17 substantially equivalent hospital and medical benefits, including a health
18 maintenance organization or a preferred provider plan, if those health care plans are
19 determined by the group insurance board to be available in the area of the place of
20 employment and are approved by the group insurance board.

21 SECTION **100hr.** 40.51 (6) (b) of the statutes is created to read:

22 40.51 **(6)** (b) Notwithstanding s. 40.03 (6) (c), in addition to the health care
23 coverage plans offered under par. (a), the state shall also offer to all of its employees
24 a defined contribution plan that permits employees to choose the level of premiums,

1 deductibles, and co–payments and to select the hospital and medical benefits offered
2 under the plan, but only if the group insurance board determines that such a defined
3 contribution plan is available in the area of the place of employment and approves
4 the plan.

5 **SECTION 100ic.** 40.98 (2) (h) of the statutes is created to read:

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

12 **SECTION 100ix.** 40.98 (6m) of the statutes is created to read:

13 40.98 **(6m)** The secretary of administration shall lapse from the appropriation
14 under s. 20.515 (2) (g) to the general fund the amounts necessary to repay the loan
15 under s. 601.34 when the secretary of administration, after consulting with the
16 board, determines that funds in the appropriation under s. 20.515 (2) (g) are
17 sufficient to make the lapse. The amounts that are required to be lapsed under s.
18 20.515 (2) (g) shall equal the amount necessary to pay all principal and interest costs
19 on the loan, less any amount that is lapsed to the general fund under s. 20.515 (2)
20 (a) at the end of the 2001–03 fiscal biennium. The secretary of administration may
21 lapse the amounts under s. 20.515 (2) (g) in installments.".

22 **6.** Page 62, line 25: after "by" insert "P.L. 106–554 and any subsequent federal
23 law related to Archer medical savings accounts under 26 USC 220,".

1 **7.** Page 63, line 2: after "by" insert "P.L. 106–554 and any subsequent federal
2 law related to Archer medical savings accounts under 26 USC 220,".
3 **8.** Page 63, line 8: after "2001," insert "and as amended by any subsequent
4 federal law related to Archer medical savings accounts under 26 USC 220,".
5 **9.** Page 63, line 19: after "106–554," insert "and any subsequent federal law
6 related to Archer medical savings accounts under 26 USC 220,".
7 **10.** Page 63, line 23: after "2001," insert "except amendments related to
8 Archer medical savings accounts under 26 USC 220,".
9 **11.** Page 76, line 1: on lines 1 and 3, after "by" insert "P.L. 106–554 and any
10 subsequent federal law related to Archer medical savings accounts under 26 USC
11 220,".
12 **12.** Page 76, line 9: after "2001," insert "and as amended by any subsequent
13 federal law related to Archer medical savings accounts under 26 USC 220,".
14 **13.** Page 76, line 22: after "106–554," insert "and any subsequent federal law
15 related to Archer medical savings accounts under 26 USC 220,".
16 **14.** Page 77, line 1: after "2001," insert "except amendments related to Archer
17 medical savings accounts under 26 USC 220,".
18 **15.** Page 85, line 25: after "by" insert "P.L. 106–554 and any subsequent
19 federal law related to Archer medical savings accounts under 26 USC 220,".
20 **16.** Page 86, line 2: after "by" insert "P.L. 106–554 and any subsequent federal
21 law related to Archer medical savings accounts under 26 USC 220,".
22 **17.** Page 86, line 8: after "2001," insert "and as amended by any subsequent
23 federal law related to Archer medical savings accounts under 26 USC 220,".

1 **18.** Page 86, line 19: after "106–554," insert "and any subsequent federal law
2 related to Archer medical savings accounts under 26 USC 220,".

3 **19.** Page 86, line 22: after "2001," insert "except amendments related to
4 Archer medical savings accounts under 26 USC 220,".

5 **20.** Page 110, line 12: on lines 12 and 14, after "by" insert "P.L. 106–554 and
6 any subsequent federal law related to Archer medical savings accounts under 26
7 USC 220,".

8 **21.** Page 110, line 22: after "2001," insert "and as amended by any subsequent
9 federal law related to Archer medical savings accounts under 26 USC 220,".

10 **22.** Page 111, line 8: after "106–554," insert "and any subsequent federal law
11 related to Archer medical savings accounts under 26 USC 220,".

12 **23.** Page 111, line 14: after "2001," insert "and as amended by any subsequent
13 federal law related to Archer medical savings accounts under 26 USC 220,".

14 **24.** Page 111, line 25: after "106–554," insert "and any subsequent federal law
15 related to Archer medical savings accounts under 26 USC 220,".

16 **25.** Page 112, line 9: after "2001," insert "and as amended by any subsequent
17 federal law related to Archer medical savings accounts under 26 USC 220,".

18 **26.** Page 112, line 20: after "106–554," insert "and any subsequent federal law
19 related to Archer medical savings accounts under 26 USC 220,".

20 **27.** Page 112, line 23: after "2001," insert "except amendments related to
21 Archer medical savings accounts under 26 USC 220,".

1 **28.** Page 123, line 11: on lines 11 and 13, after "by" insert "P.L. 106–554 and
2 any subsequent federal law related to Archer medical savings accounts under 26
3 USC 220,".

4 **29.** Page 123, line 19: after "2001," insert "and as amended by any subsequent
5 federal law related to Archer medical savings accounts under 26 USC 220,".

6 **30.** Page 124, line 7: after "106–554," insert "and any subsequent federal law
7 related to Archer medical savings accounts under 26 USC 220,".

8 **31.** Page 124, line 12: after "2001," insert "except amendments related to
9 Archer medical savings accounts under 26 USC 220,".

10 **32.** Page 134, line 10: on lines 10 and 12, after "by" insert "P.L. 106–554 and
11 any subsequent federal law related to Archer medical savings accounts under 26
12 USC 220,".

13 **33.** Page 134, line 18: after "2001," insert "and as amended by any subsequent
14 federal law related to Archer medical savings accounts under 26 USC 220,".

15 **34.** Page 135, line 3: after "106–554," insert "and any subsequent federal law
16 related to Archer medical savings accounts under 26 USC 220,".

17 **35.** Page 135, line 8: after "2001," insert "except amendments related to
18 Archer medical savings accounts under 26 USC 220,".

19 **36.** Page 172, line 10: after that line insert:

20 "SECTION **336d.** 146.96 of the statutes is created to read:

21 **146.96 Uniform claim processing form.** Beginning no later than July 1,
22 2004, every health care provider, as defined in s. 146.81 (1), shall use the uniform

1 claim processing form developed by the commissioner of insurance under s. 601.41
2 (9) (b) when submitting a claim to an insurer.".

3 **37.** Page 221, line 13: after that line insert:

4 "SECTION **508r.** 601.34 of the statutes is created to read:

5 **601.34 Loan to general fund.** No later than the first day of the 2nd month
6 after the effective date of this section .... [revisor inserts date], an amount equal to
7 $850,000 shall be lapsed from the appropriation account under s. 20.145 (1) (g) to the
8 general fund. The amount lapsed from the appropriation account shall be considered
9 a loan to the general fund and interest shall accrue on the amount lapsed at the
10 average rate earned by the state on its deposits in the state investment fund during
11 the period of the loan. The general fund shall repay the loan from moneys lapsed to
12 the general fund from the appropriation under s. 20.515 (2) (a) at the end of the
13 2001–03 fiscal biennium, if any, and from moneys lapsed to the general fund from the
14 appropriation under s. 20.515 (2) (g) in the amounts specified in s. 40.98 (6m). If the
15 secretary of administration determines that the moneys lapsed from these
16 appropriations will not be sufficient to repay the loan within a reasonable period of
17 time, as determined by the secretary and the commissioner, the secretary shall credit
18 the appropriation account under s. 20.145 (1) (g) from moneys in the general fund an
19 amount sufficient to repay the loan.

20 SECTION **508s.** 601.41 (8) of the statutes is created to read:

21 601.41 **(8)** UNIFORM EMPLOYEE APPLICATION FORM. (a) In this subsection:

22 1. "Group health benefit plan" has the meaning given in s. 632.745 (9).

23 2. "Small employer" has the meaning given in s. 635.02 (7).

24 3. "Small employer insurer" has the meaning given in s. 635.02 (8).

1 (b) In consultation with the life and disability advisory council established by
2 the commissioner, the commissioner shall by rule develop a uniform employee
3 application form that a small employer insurer must use when a small employer
4 applies for coverage under a group health benefit plan offered by the small employer
5 insurer. The commissioner shall revise the form at least every 2 years.

6 **SECTION 508t.** 601.41 (9) of the statutes is created to read:

7 601.41 **(9)** UNIFORM CLAIM PROCESSING FORM. (a) In this subsection, "health care
8 provider" has the meaning given in s. 146.81 (1).

9 (b) If the federal government has not developed by July 1, 2003, a uniform claim
10 processing form that must be used by all health care providers for submitting claims
11 to insurers and by all insurers for processing claims submitted by health care
12 providers, the commissioner shall develop, by no later than December 31, 2003, a
13 uniform claim processing form for that purpose.".

14 **38.** Page 221, line 22: after that line insert:

15 "**SECTION 509cm.** 610.65 of the statutes is created to read:

16 **610.65 Uniform claim processing form.** Beginning no later than July 1,
17 2004, every insurer shall use the uniform claim processing form developed by the
18 commissioner under s. 601.41 (9) (b) when processing a claim submitted by a health
19 care provider, as defined in s. 146.81 (1).".

20 **39.** Page 221, line 25: after that line insert:

21 "**SECTION 509gc.** 632.835 (2) (b) of the statutes, as created by 1999 Wisconsin
22 Act 155, is amended to read:

23 632.835 **(2)** (b) ~~Whenever~~ <u>If</u> an adverse determination or an experimental
24 treatment determination is made, the insurer involved in the determination shall

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

7 **SECTION 509gd.** 632.835 (2) (bg) of the statutes is created to read:

8 632.835 **(2)** (bg) Notwithstanding par. (b), an insurer is not required to provide
9 the notice under par. (b) to an insured until the insurer sends notice of the disposition
10 of the internal grievance, if all of the following apply:

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

16 2. The insurer includes on its explanation of benefits form a statement that the
17 insured may have a right to an independent review after the internal grievance
18 process and that an insured may be entitled to expedited independent review with
19 respect to an urgent matter. The statement shall also include a reference to the
20 section of the policy or certificate that contains the description of the independent
21 review procedure as required under subd. 1. The statement shall provide a toll–free
22 telephone number and website, if appropriate, where consumers may obtain
23 additional information regarding internal grievance and independent review
24 processes.

1 3. For any adverse determination or experimental treatment determination for
2 which an explanation of benefits is not provided to the insured, the insurer provides
3 a notice that the insured may have a right to an independent review after the
4 internal grievance process and that an insured may be entitled to expedited,
5 independent review with respect to an urgent matter. The notice shall also include
6 a reference to the section of the policy or certificate that contains the description of
7 the independent review procedure as required under subd. 1. The notice shall
8 provide a toll–free telephone number and website, if appropriate, where consumers
9 may obtain additional information regarding internal grievance and independent
10 review processes.

11 **SECTION 509jm.** 635.10 of the statutes is created to read:

12 **635.10 Uniform employee application.** Beginning no later than the first
13 day of the 13th month beginning after the effective date of this section .... [revisor
14 inserts date], every small employer insurer shall use the uniform employee
15 application form developed by the commissioner by rule under s. 601.41 (8) (b) when
16 a small employer applies for coverage under a group health benefit plan offered by
17 the small employer insurer.

18 **SECTION 509mp.** 635.25 of the statutes is created to read:

19 **635.25 Catastrophic risk. (1)** DEFINITION. In this section, "board" means the
20 small employer catastrophic reinsurance board.

21 **(2)** THRESHOLDS FOR COVERED BENEFITS. (a) By December 1, 2002, and every 2
22 years thereafter until December 1, 2006, every small employer insurer that chooses
23 to participate in the program under this section shall select, and submit a report to
24 the commissioner that specifies, the small employer insurer's threshold level of
25 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. In addition, the small employer insurer may in the report limit the covered benefits to which the threshold level applies, which may be costs of one or more types of health care facilities, as defined in s. 146.997 (1) (c), costs of one or more types of health care professionals, as defined in s. 180.1901 (1m), or any combination of those costs.

(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 applicable covered benefits paid in a calendar year, beginning with 2003 and ending with 2007, by the small employer insurer on behalf of any insured under any group health benefit plan to which this section applies exceeds the threshold level of covered benefits specified in the report, the commissioner, at the direction of the board, shall reimburse the small employer insurer from the appropriation under s. 20.145 (1) (j), in accordance with the procedures established by rule under sub. (5) (e), for 80% of the amount paid by the small employer insurer in that calendar year in excess of the threshold level specified in the report.

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

1 program under this section shall charge a total premium that includes the premium
2 amount established by rule under sub. (5) (a).

3 (b) By the date specified by rule under sub. (5) (c), a small employer insurer that
4 chooses to participate in the program under this section shall forward to the board
5 the premiums established by rule under sub. (5) (a), in the manner required by rule
6 under sub. (5) (d). The board shall credit all premium amounts received under this
7 paragraph to the appropriation account under s. 20.145 (1) (j).

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

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

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

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

21 **(4)** PROVIDER DISCOUNTS. (a) The commissioner shall promulgate a rule
22 determined by the board that establishes provider discount rates for charges for
23 covered services provided to insureds under group health benefit plans that are
24 issued or renewed to small employers in this state on or between the dates specified
25 by rule under sub. (5) (b). The rule may provide for higher provider discount rates

1 for covered benefits under group health benefit plans that are issued by small
2 employer insurers that specify higher threshold levels under sub. (2) (a). The rule
3 shall provide that a provider's charges for which a small employer insurer seeks
4 reimbursement shall be discounted in the same proportion that the provider's
5 charges bears to the total amount of provider charges for which the small employer
6 insurer seeks reimbursement. The provider discount rates under this paragraph
7 apply only to services for which the commissioner provides reimbursement under
8 sub. (2) (c).

9 (b) Except for copayments, coinsurance, or deductibles required or authorized
10 under a group health benefit plan, a provider of a covered service, drug, or device
11 shall accept as payment in full for the covered service, drug, or device the discounted
12 payment rate under par. (a) and may not bill the insured under the group health
13 benefit plan who receives the service, drug, or device for any amount by which the
14 charge is reduced under par. (a).

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

17 (a) Establish and periodically adjust the premium amounts that must be
18 charged to small employers under sub. (3) (c) 3. by small employer insurers that
19 choose to participate in the program under this section. The premium amounts
20 under sub. (3) (c) 3. shall be based on an actuarily sound charge per covered
21 individual that is calculated to generate sufficient moneys, in conjunction with
22 provider discounts under sub. (4), to cover the reimbursements required under sub.
23 (2) (c).

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

1 (c) Specify the dates by which a small employer insurer must forward to the
2 board the premiums established under par. (a). The first date by which the
3 premiums must be forwarded to the board may not be later than July 1, 2003.
4 (d) Specify the procedures that small employer insurers must use for collecting,
5 segregating, holding in trust, and forwarding to the board the premiums established
6 under par. (a).
7 (e) Specify the procedures that small employer insurers must use for obtaining
8 reimbursement under sub. (2) (c), including requirements for documenting the
9 payment of covered benefits for determining whether a small employer insurer has
10 paid its threshold level of covered benefits.".
11 **40.** Page 352, line 12: after that line insert:
12 "(9q) PRESCRIPTION DRUG COST REDUCTION; REPORT. (a) By January 1, 2003, the
13 department of administration shall submit a report that identifies all of the
14 following:
15 1. The participation by health care providers, insurers, and self–insurers in
16 negotiating rebate agreements under section 16.735 (2) (a) of the statutes, as created
17 by this act, and in developing in–state or multistate purchasing groups to negotiate
18 reduced charges under section 16.735 (2) (b) of the statutes, as created by this act.
19 2. Strategies that the department of administration proposes to pursue to
20 reduce costs for prescription drugs in this state.
21 (b) By January 1, 2005, the department of administration shall submit a report
22 that specifies the status of implementing section 16.735 of the statutes, as created
23 by this act, including any success or lack of success in reducing costs for prescription
24 drugs in this state.

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

5 **41.** Page 358, line 21: after that line insert:

6 "(1q) SMALL EMPLOYER CATASTROPHIC REINSURANCE BOARD. Notwithstanding the
7 length of terms specified for the members of the small employer catastrophic
8 reinsurance board under section 15.735 (1) (b) of the statutes, as created by this act,
9 the initial members shall be appointed for the following terms:

10 (a) One member representing small employers, one member representing
11 small employer insurers, and one member representing hospitals, for terms expiring
12 on May 1, 2005.

13 (b) Two members representing small employer insurers, and the member who
14 is a physician, for terms expiring on May 1, 2006.

15 (c) One member representing small employers, one member representing small
16 employer insurers, one member representing hospitals, and the member who is a
17 nurse, for terms expiring on May 1, 2007.

18 (2q) RULES RELATED TO SMALL EMPLOYER INSURER CATASTROPHIC RISK. Using the
19 procedure under section 227.24 of the statutes, the commissioner of insurance may
20 promulgate the rules required under section 635.25 (4) (a) and (5) of the statutes, as
21 created by this act, for the period before the effective date of the permanent rules
22 required under section 635.25 (4) (a) and (5) of the statutes, as created by this act,
23 but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the
24 statutes. Notwithstanding section 227.24 (1) (a), (2) (b), and (3) of the statutes, the

1 commissioner is not required to provide evidence that promulgating a rule under this
2 subsection as an emergency rule is necessary for the preservation of public peace,
3 health, safety, or welfare and is not required to provide a finding of emergency for a
4 rule promulgated under this subsection.

5 (3q) UNIFORM EMPLOYEE APPLICATION FORM RULES. The commissioner of
6 insurance shall submit in proposed form the rules required under section 601.41 (8)
7 (b) of the statutes, as created by this act, to the legislative council staff under section
8 227.15 (1) of the statutes no later than the first day of the 5th month beginning after
9 the effective date of this subsection.".

10 **42.** Page 359, line 1: after that line insert:

11 "(1q) HEALTH INSURANCE COSTS STUDY. The joint legislative council is requested
12 to conduct a study on the rising costs of health insurance. If the joint legislative
13 council conducts the study, it shall report its findings and conclusions to the
14 legislature in the manner provided under section 13.172 (2) of the statutes.".

15 **43.** Page 388, line 16: after that line insert:

16 "(2q) PRIVATE EMPLOYER HEALTH CARE COVERAGE PROGRAM. In the schedule under
17 section 20.005 (3) of the statutes for the appropriation to the department of employee
18 trust funds under section 20.515 (2) (a) of the statutes, as affected by the acts of 2001,
19 the dollar amount is increased by $850,000 for fiscal year 2001–02 to increase
20 funding for the purpose for which the appropriation is made.

21 (2r) HIRING FREEZE EXEMPTION. Notwithstanding any action of the governor or
22 the secretary of administration under section 16.505 (3) of the statutes before the
23 effective date of this subsection, the department of employee trust funds may fill 3.5
24 FTE GPR positions that are vacant on the effective date of this subsection, that are

1 authorized to the department under section 16.505 of the statutes, and that are
2 funded from the appropriation under section 20.512 (2) (a) of the statutes.".

3 **44.** Page 446, line 13: after that line insert:

4 "(1q) NOTICE OF INDEPENDENT REVIEW. The treatment of section 632.835 (2) (b)
5 and (bg) of the statutes takes effect on the date stated in the notice published by the
6 commissioner of insurance in the Wisconsin Administrative Register under section
7 632.835 (8) of the statutes.".

8 **(END)**