



State of Wisconsin
2003 - 2004 LEGISLATURE

LRB-2476/3

PJK:kmg:rs

missouri

2003 BILL

*needed
Thurs.
(tomorrow)*
pp. 9, 17, 27, 30, and 31
(8)

regenerate ↓

1 AN ACT *to repeal* 149.14 (3) (a) to (r), 149.14 (4), 149.14 (4c), 149.15 (3) (c), 149.15
2 (3) (f), 149.15 (5) and 149.16; *to renumber and amend* 149.14 (3) (intro.); *to*
3 *amend* 25.55 (3), 49.475 (2) (a) (intro.), 149.10 (3), 149.11, 149.115, 149.12 (1)
4 (a), 149.12 (1) (am), 149.12 (1) (b), 149.12 (1) (c), 149.12 (3) (c), 149.13 (1), 149.13
5 (3), 149.13 (4), 149.14 (5) (d), 149.14 (5) (e), 149.14 (5m) (c), 149.14 (7) (b) and
6 (c), 149.14 (8), 149.142 (1), 149.143 (1) (intro.), 149.143 (1) (intro.), 149.143 (1)
7 (am) 1., 149.143 (1) (am) 3., 149.143 (1) (am) 4., 149.143 (1) (bm) 1., 149.143 (1)
8 (bm) 2., 149.143 (2) (a) (intro.), 149.143 (2) (a) 2., 149.143 (2) (a) 4., 149.143 (2)
9 (b), 149.143 (2) (b), 149.143 (2m) (a) (intro.), 149.143 (2m) (b) 1., 149.143 (2m)
10 (b) 2., 149.143 (2m) (b) 3., 149.143 (3) (a), 149.143 (3) (a), 149.143 (3) (b), 149.143
11 (3) (b), 149.143 (3m), 149.143 (4), 149.143 (4), 149.143 (5) (a), 149.143 (5) (a),
12 149.143 (5) (b), 149.144, 149.144, 149.145, 149.145, 149.146 (1) (b), 149.146 (2)
13 (a), 149.146 (2) (am) 4., 149.146 (2) (am) 5., 149.146 (2) (b) (intro.), 149.146 (2)
14 (b) 1., 149.146 (2) (b) 2., 149.15 (1), 149.165 (1), 149.165 (2), 149.165 (3) (a),

BILL

1 149.165 (3) (b) (intro.), 149.17 (4), 149.175, 149.20, 149.25 (2) (a) and 149.25 (4);
2 and *to create* 149.10 (5f), 149.10 (5r), 149.125, 149.132, 149.142 (3), 149.143
3 (1) (bm) 1m., 149.143 (2) (a) 3m., 149.143 (2m) (c), 149.143 (3c), 149.15 (3) (b),
4 149.15 (3) (e), 149.15 (3) (em), 149.15 (4) (c), 149.165 (3r) and 450.10 (2m) of the
5 statutes; **relating to:** making various miscellaneous changes to the Health
6 Insurance Risk-Sharing Plan, granting rule-making authority, and providing
7 a penalty.

Analysis by the Legislative Reference Bureau

The Health Insurance Risk-Sharing Plan (HIRSP) provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus, 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. Also eligible for coverage are persons who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past.

Premiums paid by covered persons fund 60 percent of the operating costs of HIRSP and health insurer assessments and health care provider payment discounts fund the remaining 40 percent of operating costs. HIRSP provides premium and deductible subsidies for covered persons with annual household incomes below \$25,000. The subsidies are funded equally by health insurer assessments and health care provider payment discounts. HIRSP is administered primarily by the Department of Health and Family Services (DHFS), but a board of governors (board) and a plan administrator also have certain responsibilities and powers with respect to HIRSP administration.

This bill makes the following changes to HIRSP:

1. Under the bill, prescription drug manufacturers or labelers that provide drugs prescribed for use by persons covered under HIRSP are required to pay an assessment, as are health insurers currently, for plan costs. DHFS must determine which drug manufacturers and labelers are affected. The bill requires any drug manufacturer or labeler that provides drugs prescribed for use by persons receiving benefits under Medical Assistance, BadgerCare, or SeniorCare to provide drugs prescribed for use by persons with coverage under HIRSP. A drug manufacturer's or labeler's assessment will be based on its gross revenues in the preceding calendar year that were derived from drug sales to persons with coverage under HIRSP. The 40 percent of HIRSP's costs that are now split equally between insurer assessments and provider payment discounts, as well as the premium and deductible subsidies for lower-income covered persons, will be paid one-third by insurer assessments,

BILL

one-third by provider payment discounts, and one-third by drug manufacturer and labeler assessments. The bill allows the Pharmacy Examining Board to assess a forfeiture of not more than \$1,000 per day against a drug manufacturer or labeler that fails to pay an assessment for HIRSP.

2. The bill removes most of the administrative responsibilities from DHFS and transfers them to the board. For example, under current law, DHFS may establish different deductible amounts and a different coinsurance percentage from what is provided in the statutes, while under the bill the board may do so; under current law, DHFS must establish payment rates by adding an enhancement determined by DHFS to the allowable charges under Medical Assistance, while under the bill the board establishes the allowable charges in the same manner and must consult with DHFS; under current law, DHFS establishes a program budget in consultation with the board and may implement the budget only if it is approved by the board, while under the bill the board establishes the program budget and must consult with DHFS in deriving the provider payment rate; under current law, prior to each plan year DHFS must estimate the operating and administrative costs of HIRSP and set premiums, insurer assessment amounts, and provider payment rate discounts, while under the bill the board performs these functions, as well as setting the drug manufacturer and labeler assessment amounts; and under current law, DHFS is required to promulgate rules for the operation of HIRSP and must consult with the board before promulgating any rules related to HIRSP, while under the bill the board is required to promulgate rules for the design and operation of HIRSP, consulting with DHFS as necessary, and DHFS may promulgate a rule only if the board has approved the proposed rule.

3. Under current law, the secretary of health and family services, or his or her representative, is the chairperson of the board. The bill provides that the board will annually select the chairperson. The bill also adds a representative of Pharmaceutical Research and Manufacturers of America to the board, the members of which are appointed by the secretary of health and family services.

4. Under current law, expenses covered under HIRSP and exclusions are set out in the statutes. The bill eliminates those provisions and requires the board to establish by rule the plan design, including covered expenses and exclusions.

5. Under current law, DHFS may select the plan administrator in a competitive bidding process. The bill requires the board to select the plan administrator in a competitive, request-for-proposals process and allows the board to contract with other persons to provide professional services to the board and HIRSP.

6. The bill allows the board to establish for covered persons with annual household incomes over \$100,000 a separate schedule of premium rates that are higher than the rates for other covered persons. The additional premium collected must be used to further reduce the premiums paid by lower-income covered persons who receive a subsidy for premiums and deductibles.

7. Under current law, a person is eligible for HIRSP coverage if he or she is rejected for coverage by one or more insurers, has coverage canceled by one or more insurers, or receives notice of a substantial reduction in coverage or a 50 percent increase in premium. Under the bill, a person is eligible if he or she is rejected for

BILL

coverage by two or more insurers or if he or she is rejected for coverage by at least one insurer in addition to having coverage canceled or reduced, or premiums increased, by one or more insurers.

8. Under current law, a person is not eligible for coverage under HIRSP if he or she is eligible for coverage provided by an employer. The bill requires DHFS to verify information that an applicant provides about his or her employment and whether health care coverage is available through that employment and to periodically verify the information if the person receives coverage under HIRSP. DHFS must maintain a data base with the information and submit a quarterly report to the board on the information.

9. Finally, the bill requires that any federal grant moneys received by the state under the Trade Adjustment Assistance Reform Act of 2002 be used for HIRSP to pay plan costs before any costs are paid with premiums or insurer and drug manufacturer and labeler assessments and provider payment discounts.

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:

1 **SECTION 1.** 25.55 (3) of the statutes is amended to read:

2 25.55 (3) Insurer and drug manufacturer and labeler assessments under ch.
3 149.

4 **SECTION 2.** 49.475 (2) (a) (intro.) of the statutes is amended to read:

5 49.475 (2) (a) (intro.) Information that the department needs to identify
6 beneficiaries of medical assistance, and persons applying for coverage or who are
7 covered under the Health Insurance Risk-Sharing Plan under ch. 149, who satisfy
8 any of the following:

9 **SECTION 3.** 149.10 (3) of the statutes is amended to read:

10 149.10 (3) “Eligible person” means a resident of ~~this state~~ who qualifies under
11 s. 149.12 whether or not the person is legally responsible for the payment of medical
12 expenses incurred on the person’s behalf.

13 **SECTION 4.** 149.10 (5f) of the statutes is created to read:

BILL

1 149.10 (5f) “Labeler” means a person that receives prescription drugs from a
2 manufacturer or wholesaler and repackages those drugs for later retail sale and that
3 has a labeler code issued by the federal food and drug administration under 21 CFR
4 207.20 (b).

5 **SECTION 5.** 149.10 (5r) of the statutes is created to read:

6 149.10 (5r) “Manufacturer” means a person engaged in the production,
7 preparation, propagation, compounding, conversion, or processing of prescription
8 drugs.

9 **SECTION 6.** 149.11 of the statutes is amended to read:

10 **149.11 Operation of plan.** The department board shall promulgate rules for
11 the design and operation of a plan of health insurance coverage for ~~an~~ eligible person
12 ~~which persons that~~ satisfies the requirements of this chapter. The board shall
13 consult with the department as necessary in promulgating the rules under this
14 section. The department shall provide the board with the support necessary for the
15 board to carry out its responsibilities under this chapter.

16 **SECTION 7.** 149.115 of the statutes is amended to read:

17 **149.115 Rules relating to creditable coverage.** The commissioner, in
18 consultation with the department and the board, shall promulgate rules that specify
19 how creditable coverage is to be aggregated for purposes of s. 149.10 (2t) (a) and that
20 determine the creditable coverage to which s. 149.10 (2t) (b) and (d) applies. The
21 rules shall comply with section 2701 (c) of P.L. 104–191.

22 **SECTION 8.** 149.12 (1) (a) of the statutes is amended to read:

23 149.12 (1) (a) A notice of rejection of coverage from ~~one~~ 2 or more insurers.

24 **SECTION 9.** 149.12 (1) (am) of the statutes is amended to read:

BILL

1 149.12 (1) (am) A notice of rejection of coverage from one or more insurers and
2 a notice of cancellation of coverage from one or more insurers.

3 **SECTION 10.** 149.12 (1) (b) of the statutes is amended to read:

4 149.12 (1) (b) A notice of rejection of coverage from one or more insurers and
5 a notice of reduction or limitation of coverage, including restrictive riders, from an
6 insurer if the effect of the reduction or limitation is to substantially reduce coverage
7 compared to the coverage available to a person considered a standard risk for the
8 type of coverage provided by the plan.

9 **SECTION 11.** 149.12 (1) (c) of the statutes is amended to read:

10 149.12 (1) (c) A notice of rejection of coverage from one or more insurers and
11 a notice of increase in premium exceeding the premium then in effect for the insured
12 person by 50% or more, unless the increase applies to substantially all of the
13 insurer's health insurance policies then in effect.

14 **SECTION 12.** 149.12 (3) (c) of the statutes is amended to read:

15 149.12 (3) (c) The department board may promulgate rules specifying other
16 deductible or coinsurance amounts that, if paid or reimbursed for persons, will not
17 make the persons ineligible for coverage under the plan.

18 **SECTION 13.** 149.125 of the statutes is created to read:

19 **149.125 Employment verification; maintenance of data; report.** (1) In
20 determining a person's initial and continued eligibility, the department shall verify,
21 at the time that the person applies for coverage and periodically thereafter,
22 information submitted by the person about his or her employment and whether
23 creditable coverage is available to the person. The department shall use information
24 obtained under s. 49.475 for verification purposes under this subsection.

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1 (2) The department shall maintain and regularly update a computer data base
2 with information about eligible persons that includes employment status and
3 economic and demographic information. The department shall submit a quarterly
4 report to the board on the information contained in the data base.

5 **SECTION 14.** 149.13 (1) of the statutes is amended to read:

6 149.13 (1) Every insurer shall participate in the cost of administering the plan,
7 except that the commissioner may by rule exempt as a class those insurers whose
8 share as determined under sub. (2) would be so minimal as ~~to~~ not to exceed the
9 estimated cost of levying the assessment. The commissioner shall advise the
10 ~~department~~ board of the insurers participating in the cost of administering the plan.

11 **SECTION 15.** 149.13 (3) of the statutes is amended to read:

12 149.13 (3) (a) Each insurer's proportion of participation under sub. (2) shall be
13 determined annually by the commissioner based on annual statements and other
14 reports filed by the insurer with the commissioner. The commissioner shall assess
15 an insurer for the insurer's proportion of participation based on the total
16 assessments estimated by the ~~department~~ board under s. 149.143 (2) (a) 3.

17 (b) If the department ~~or the~~, commissioner, or board finds that the
18 commissioner's authority to require insurers to report under chs. 600 to 646 and 655
19 is not adequate to permit the department, the commissioner, or the board to carry out
20 the department's, commissioner's, or board's responsibilities under this chapter, the
21 commissioner shall promulgate rules requiring insurers to report the information
22 necessary for the department, commissioner, and board to make the determinations
23 required under this chapter.

24 **SECTION 16.** 149.13 (4) of the statutes is amended to read:

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1 149.13 (4) Notwithstanding subs. (1) to (3), the department, with the
2 agreement of the commissioner and the board, may perform various administrative
3 functions related to the assessment of insurers participating in the cost of
4 administering the plan.

5 **SECTION 17.** 149.132 of the statutes is created to read:

6 **149.132 Participation of manufacturers and labelers.** (1) The
7 department shall determine the manufacturers and labelers of prescription drugs
8 that are sold, or otherwise provided, to eligible persons who are covered under the
9 plan. Any manufacturer or labeler of prescription drugs that are sold, or otherwise
10 provided, to persons in this state who receive health care coverage benefits under the
11 Medical Assistance program under subch. IV of ch. 49, the Badger Care health care
12 program under s. 49.665, or the prescription drug assistance for elderly persons
13 program under s. 49.688 is required to sell prescription drugs for the prescribed use
14 and purchase by eligible persons covered under the plan.

15 (b) The manufacturers and labelers specified by the department under par. (a)
16 shall share in the operating, administrative, and subsidy expenses of the plan in the
17 manner provided in ss. 149.143 and 149.144, except that the board may by rule
18 exempt as a class those manufacturers and labelers whose shares as determined
19 under sub. (2) would be so minimal as not to exceed the estimated cost of levying the
20 assessment.

21 (2) The board shall determine the methodology for assessing manufacturers
22 and labelers, including each manufacturer's or labeler's proportion of participation
23 in the costs of the plan. Each manufacturer's and each labeler's proportion of
24 participation shall be determined annually and shall be based on the manufacturer's
25 or labeler's gross revenues in the preceding calendar year that were derived from

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1 prescription drugs sold or otherwise provided to ^{eligible} ~~the~~ persons ~~specified in subsection (4)~~. The
2 board shall consult with the department as necessary in determining the
3 methodology under this subsection.

4 (3) The department shall levy and collect the assessments and deposit the
5 amounts collected in the health insurance risk-sharing plan fund.

6 **SECTION 18.** 149.14 (3) (intro.) of the statutes is renumbered 149.14 (3) and
7 amended to read:

8 149.14 (3) COVERED EXPENSES. Except as provided in sub. (4), ~~except as~~
9 restricted by cost containment provisions under s. 149.17 (4) and except as reduced
10 by the department board under ss. 149.143 and 149.144, covered expenses for the
11 coverage under this section shall be the payment rates established by the
12 department under s. 149.142 for the services provided by persons licensed under ch.
13 446 and certified under s. 49.45 (2) (a) 11. ~~Except as provided in sub. (4), except as~~
14 restricted by cost containment provisions under s. 149.17 (4) and except as reduced
15 by the department board under ss. 149.143 and 149.144, covered expenses for the
16 coverage under this section shall also be the payment rates established by the
17 department under s. 149.142 for the following services and articles specified by the
18 board if the service or article is prescribed by a physician who is licensed under ch.
19 448 or in another state and who is certified under s. 49.45 (2) (a) 11. and if the service
20 or article is provided by a provider certified under s. 49.45 (2) (a) 11.:

21 **SECTION 19.** 149.14 (3) (a) to (r) of the statutes are repealed.

22 **SECTION 20.** 149.14 (4) of the statutes is repealed.

23 **SECTION 21.** 149.14 (4c) of the statutes is repealed.

24 **SECTION 22.** 149.14 (5) (d) of the statutes is amended to read:

with coverage under the plan

BILL

1 149.14 (5) (d) Notwithstanding pars. (a) to (c), the ~~department~~ board may
2 establish different deductible amounts, a different coinsurance percentage, and
3 different covered costs and deductible aggregate amounts from those specified in
4 pars. (a) to (c) in accordance with cost containment provisions established by the
5 ~~department~~ board under s. 149.17 (4).

6 **SECTION 23.** 149.14 (5) (e) of the statutes, as affected by 2003 Wisconsin Act 33,
7 is amended to read:

8 149.14 (5) (e) Subject to sub. (8) (b), the ~~department~~ board may, by rule under
9 s. 149.17 (4), establish for prescription drug coverage under sub. ~~(3) (d)~~ this section
10 copayment amounts, coinsurance rates, and copayment and coinsurance
11 out-of-pocket limits over which the plan will pay 100% of covered costs ~~under sub.~~
12 ~~(3) (d)~~ for prescription drugs. The ~~department~~ board may provide subsidies for
13 prescription drug copayment amounts paid by eligible persons under s. 149.165 (2)
14 (a) 1. to 5. ~~Any copayment amount, coinsurance rate, or out-of-pocket limit~~
15 ~~established under this paragraph is subject to the approval of the board.~~
16 Copayments and coinsurance paid by an eligible person under this paragraph are
17 separate from and do not count toward the deductible and covered costs not paid by
18 the plan under pars. (a) to (c).

19 **SECTION 24.** 149.14 (5m) (c) of the statutes is amended to read:

20 149.14 (5m) (c) Other economic factors that the ~~department and the board~~
21 ~~consider~~ considers relevant.

22 **SECTION 25.** 149.14 (7) (b) and (c) of the statutes are amended to read:

23 149.14 (7) (b) The ~~department~~ board has a cause of action against an eligible
24 ~~participant person~~ person for the recovery of the amount of benefits paid ~~which~~ that are not

BILL

1 for covered expenses under the plan. Benefits under the plan may be reduced or
2 refused as a setoff against any amount recoverable under this paragraph.

3 (c) The department board is subrogated to the rights of an eligible person to
4 recover special damages for illness or injury to the person caused by the act of a 3rd
5 person to the extent that benefits are provided under the plan. Section 814.03 (3)
6 applies to the department board under this paragraph.

7 **SECTION 26.** 149.14 (8) of the statutes is amended to read:

8 149.14 (8) APPLICABILITY OF MEDICAL ASSISTANCE PROVISIONS. (a) Except as
9 provided in par. (b), the department board may, by rule under s. 149.17 (4), apply to
10 the plan the same utilization and cost control procedures that apply under rules
11 promulgated by the department to medical assistance ~~under subch. IV of ch. 49.~~ The
12 board shall consult with the department as necessary in the application of the
13 utilization and cost control procedures specified in this paragraph.

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

17 **SECTION 27.** 149.142 (1) of the statutes is amended to read:

18 149.142 (1) (a) Except as provided in par. (b), the department board shall
19 establish payment rates for covered expenses that consist of the allowable charges
20 paid under s. 49.46 (2) for the services and articles provided plus an enhancement
21 determined by the department board. The rates shall be based on the allowable
22 charges paid under s. 49.46 (2), projected plan costs, and trend factors. Using the
23 same methodology that applies to medical assistance ~~under subch. IV of ch. 49,~~ the
24 ~~department board~~ shall establish hospital outpatient per visit reimbursement rates
25 and hospital inpatient reimbursement rates that are specific to diagnostically

BILL

1 related groups of eligible persons. The board shall consult with the department in
2 establishing the payment and reimbursement rates under this paragraph.

3 (b) The payment rate for a prescription drug shall be the allowable charge paid
4 under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4),
5 the ~~department~~ board may not reduce the payment rate for prescription drugs below
6 the rate specified in this paragraph, and the rate may not be adjusted under s.
7 149.143 or 149.144.

8 **SECTION 28.** 149.142 (3) of the statutes is created to read:

9 149.142 (3) Whenever a claim is processed for payment, the adjustment of a
10 provider's payment rate under sub. (1) and any adjustment under s. 149.143 or
11 149.144 shall be calculated and applied on a per-claim basis. The adjustment shall
12 be disclosed on the explanation-of-benefits form provided to the eligible person and
13 to the provider.

14 **SECTION 29.** 149.143 (1) (intro.) of the statutes is amended to read:

15 149.143 (1) (intro.) The department shall pay or recover the operating costs of
16 the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of
17 the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining
18 premiums, insurer assessments, and provider payment rate adjustments, the
19 ~~department~~ board shall apportion and prioritize responsibility for payment or
20 recovery of plan costs from among the moneys constituting the fund as follows:

21 **SECTION 30.** 149.143 (1) (intro.) of the statutes, as affected by 2003 Wisconsin
22 Act ... (this act), is amended to read:

23 149.143 (1) (intro.) The department shall pay or recover the operating costs of
24 the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of
25 the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining

BILL

1 premiums, insurer, manufacturer, and labeler assessments, and provider payment
2 rate adjustments, the board shall apportion and prioritize responsibility for payment
3 or recovery of plan costs from among the moneys constituting the fund as follows:

4 **SECTION 31.** 149.143 (1) (am) 1. of the statutes, as affected by 2003 Wisconsin
5 Act 33, is amended to read:

6 149.143 (1) (am) 1. First, from premiums from eligible persons with coverage
7 under s. 149.14 (2) (a) set at a rate that is 140% to 150% of the rate that a standard
8 risk would be charged under an individual policy providing substantially the same
9 coverage and ~~deductibles~~ cost-sharing provisions as are provided under the plan and
10 from eligible persons with coverage under s. 149.14 (2) (b) set in accordance with s.
11 149.14 (5m), including amounts received for premium, deductible, and prescription
12 drug copayment subsidies under s. 149.144, and from premiums collected from
13 eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2)
14 (b).

15 **SECTION 32.** 149.143 (1) (am) 3. of the statutes, as affected by 2003 Wisconsin
16 Act 33, is amended to read:

17 149.143 (1) (am) 3. Third, by increasing premiums from eligible persons with
18 coverage under s. 149.14 (2) (a) to more than the rate at which premiums were set
19 under subd. 1. but not more than 200% of the rate that a standard risk would be
20 charged under an individual policy providing substantially the same coverage and
21 ~~deductibles~~ cost-sharing provisions as are provided under the plan and from eligible
22 persons with coverage under s. 149.14 (2) (b) by a comparable amount in accordance
23 with s. 149.14 (5m), including amounts received for premium, deductible, and
24 prescription drug copayment subsidies under s. 149.144, and by increasing
25 premiums from eligible persons with coverage under s. 149.146 in accordance with

BILL

1 s. 149.146 (2) (b), to the extent that the amounts under subds. 1. and 2. are
2 insufficient to pay 60% of plan costs.

3 **SECTION 33.** 149.143 (1) (am) 4. of the statutes, as affected by 2003 Wisconsin
4 Act 33, is amended to read:

5 149.143 (1) (am) 4. Fourth, notwithstanding par. (bm), by increasing insurer
6 assessments, excluding assessments under s. 149.144, increasing manufacturer and
7 labeler assessments, excluding assessments under s. 149.144, and adjusting
8 provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to
9 those rates under s. 149.144, in equal proportions and to the extent that the amounts
10 under subds. 1. to 3. are insufficient to pay 60% of plan costs.

11 **SECTION 34.** 149.143 (1) (bm) 1. of the statutes, as affected by 2003 Wisconsin
12 Act 33, is amended to read:

13 149.143 (1) (bm) 1. ~~Fifty percent~~ One-third from insurer assessments,
14 excluding assessments under s. 149.144.

15 **SECTION 35.** 149.143 (1) (bm) 1m. of the statutes is created to read:

16 149.143 (1) (bm) 1m. ~~One-third~~ from manufacturer and labeler assessments,
17 excluding assessments under s. 149.144.

18 **SECTION 36.** 149.143 (1) (bm) 2. of the statutes, as affected by 2003 Wisconsin
19 Act 33, is amended to read:

20 149.143 (1) (bm) 2. ~~Fifty percent~~ One-third from adjustments to provider
21 payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates
22 under s. 149.144.

23 **SECTION 37.** 149.143 (2) (a) (intro.) of the statutes, as affected by 2003
24 Wisconsin Act 33, is amended to read:

BILL

1 149.143 (2) (a) (intro.) Prior to each plan year, the department board shall
2 estimate the operating and administrative costs of the plan and the costs of the
3 premium reductions under s. 149.165 (2) and (3), the deductible reductions under s.
4 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5)
5 (e) for the new plan year and do all of the following:

6 **SECTION 38.** 149.143 (2) (a) 2. of the statutes, as affected by 2003 Wisconsin Act
7 33, is amended to read:

8 149.143 (2) (a) 2. After making the determinations under subd. 1., by rule set
9 premium rates for the new plan year, including the rates under s. 149.146 (2) (b), in
10 the manner specified in sub. (1) (am) 1. and 3. and such that a rate for coverage under
11 s. 149.14 (2) (a) is ~~approved by the board and~~ is not less than 140% nor more than
12 200% of the rate that a standard risk would be charged under an individual policy
13 providing substantially the same coverage and ~~deductibles~~ cost-sharing provisions
14 as are provided under the plan.

15 **SECTION 39.** 149.143 (2) (a) 3m. of the statutes is created to read:

16 149.143 (2) (a) 3m. By the same rule as under subd. 3., set the total
17 manufacturer and labeler assessments under s. 149.132 for the new plan year by
18 estimating and setting the assessments at the amount necessary to equal the
19 amounts specified in sub. (1) (am) 4. and (bm) 1m. and notify the department of the
20 amount.

21 **SECTION 40.** 149.143 (2) (a) 4. of the statutes, as affected by 2003 Wisconsin Act
22 33, is amended to read:

23 149.143 (2) (a) 4. By the same rule as under ~~subd. 3.~~ subds. 3. and 3m., adjust
24 the provider payment rate for the new plan year, subject to s. 149.142 (1) (b), by

BILL

1 estimating and setting the rate at the level necessary to equal the amounts specified
2 in sub. (1) (am) 4. and (bm) 2. and as provided in s. 149.145.

3 **SECTION 41.** 149.143 (2) (b) of the statutes, as affected by 2003 Wisconsin Act
4 33, is amended to read:

5 149.143 (2) (b) In setting the premium rates under par. (a) 2., the insurer
6 assessment amount under par. (a) 3., and the provider payment rate under par. (a)
7 4. for the new plan year, the ~~department~~ board shall include any increase or decrease
8 necessary to reflect the amount, if any, by which the rates and amount set under par.
9 (a) for the current plan year differed from the rates and amount which would have
10 equaled the amounts specified in sub. (1) (am) and (bm) in the current plan year.

11 **SECTION 42.** 149.143 (2) (b) of the statutes, as affected by 2003 Wisconsin Act
12 (this act), is amended to read:

13 149.143 (2) (b) In setting the premium rates under par. (a) 2., the insurer
14 assessment amount under par. (a) 3., the manufacturer and labeler assessment
15 amount under par. (a) 3m., and the provider payment rate under par. (a) 4. for the
16 new plan year, the board shall include any increase or decrease necessary to reflect
17 the amount, if any, by which the rates and amount set under par. (a) for the current
18 plan year differed from the rates and amount which would have equaled the amounts
19 specified in sub. (1) (am) and (bm) in the current plan year.

20 **SECTION 43.** 149.143 (2m) (a) (intro.) of the statutes is amended to read:

21 149.143 (2m) (a) (intro.) The ~~department~~ board shall keep a separate
22 accounting of the difference between the following:

23 **SECTION 44.** 149.143 (2m) (b) 1. of the statutes, as affected by 2003 Wisconsin
24 Act 33, is amended to read:

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1 149.143 (2m) (b) 1. To reduce premiums in succeeding plan years as provided
2 in sub. (1) (am) 2. For eligible persons with coverage under s. 149.14 (2) (a),
3 premiums may not be reduced below 140% of the rate that a standard risk would be
4 charged under an individual policy providing substantially the same coverage and
5 deductibles cost-sharing provisions as are provided under the plan.

6 **SECTION 45.** 149.143 (2m) (b) 2. of the statutes is amended to read:

7 149.143 (2m) (b) 2. For other needs of eligible persons, with the approval of the
8 board including the purpose specified in s. 149.15 (4) (d). ~~(e)~~ ^d

9 **SECTION 46.** 149.143 (2m) (b) 3. of the statutes is amended to read:

10 149.143 (2m) (b) 3. For distribution to eligible persons, notwithstanding any
11 requirements in this chapter related to setting premium amounts. The ~~department~~
12 board, with the ~~approval of the board and the concurrence~~ of the plan actuary, shall
13 determine the policies, eligibility criteria, methodology, and other factors to be used
14 in making any distribution under this subdivision.

15 **SECTION 47.** 149.143 (2m) (c) of the statutes is created to read:

16 149.143 (2m) (c) The board shall consult with the department as necessary for
17 the accounting under par. (a).

18 **SECTION 48.** 149.143 (3) (a) of the statutes, as affected by 2003 Wisconsin Act
19 33, is amended to read:

20 149.143 (3) (a) If, during a plan year, the ~~department~~ board determines that
21 the amounts estimated to be received as a result of the rates and amount set under
22 sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider
23 payment rate under s. 149.144 will not be sufficient to cover plan costs, the
24 ~~department~~ board may by rule increase the premium rates set under sub. (2) (a) 2.
25 for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum

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1 specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3.
2 for the remainder of the plan year, subject to sub. (1) (bm) 1., and by the same rule
3 under which assessments are increased adjust the provider payment rate set under
4 sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. and s.
5 149.142 (1) (b).

6 **SECTION 49.** 149.143 (3) (a) of the statutes, as affected by 2003 Wisconsin Act
7 (this act), is amended to read:

8 149.143 (3) (a) If, during a plan year, the board determines that the amounts
9 estimated to be received as a result of the rates and amount set under sub. (2) (a) 2.
10 to 4. and any adjustments in insurer and manufacturer and labeler assessments and
11 the provider payment rate under s. 149.144 will not be sufficient to cover plan costs,
12 the board may by rule increase the premium rates set under sub. (2) (a) 2. for the
13 remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified
14 in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. and 3m.
15 for the remainder of the plan year, subject to sub. (1) (bm) 1. and 1m., and by the same
16 rule under which assessments are increased adjust the provider payment rate set
17 under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. and
18 s. 149.142 (1) (b).

19 **SECTION 50.** 149.143 (3) (b) of the statutes, as affected by 2003 Wisconsin Act
20 33, is amended to read:

21 149.143 (3) (b) If the ~~department~~ board increases premium rates and insurer
22 assessments and adjusts the provider payment rate under par. (a) and determines
23 that there will still be a deficit and that premium rates have been increased to the
24 maximum extent allowable under par. (a), the ~~department~~ board may further adjust,
25 in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment

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1 rate set under sub. (2) (a) 4., without regard to sub. (1) (bm) but subject to s. 149.142
2 (1) (b).

3 **SECTION 51.** 149.143 (3) (b) of the statutes, as affected by 2003 Wisconsin Act
4 (this act), is amended to read:

5 149.143 (3) (b) If the board increases premium rates and insurer and
6 manufacturer and labeler assessments and adjusts the provider payment rate under
7 par. (a) and determines that there will still be a deficit and that premium rates have
8 been increased to the maximum extent allowable under par. (a), the board may
9 further adjust, in equal proportions, assessments set under sub. (2) (a) 3.,
10 assessments set under sub. (2) (a) 3m., and the provider payment rate set under sub.
11 (2) (a) 4., without regard to sub. (1) (bm) but subject to s. 149.142 (1) (b).

12 **SECTION 52.** 149.143 (3c) of the statutes is created to read:

13 149.143 (3c) Notwithstanding subs. (1) (am) 4. and (bm), (2), and (3), if during
14 a plan year the board determines that insurer and manufacturer and labeler
15 assessments and provider payment rate adjustments set and adjusted as provided
16 under subs. (1) (am) 4. and (bm), (2), and (3) will not be sufficient to cover the plan
17 costs specified in sub. (1) (am) 4. or (bm), the board may by rule adjust the amount
18 of the insurer assessments and the provider payment rate, subject to s. 149.142 (1)
19 (b), so that insurer assessments and provider payment rate adjustments, in equal
20 proportions, cover the plan costs specified in sub (1) (am) 4. or (bm).

21 **SECTION 53.** 149.143 (3m) of the statutes is amended to read:

22 149.143 (3m) Subject to s. 149.14 (4m), insurers, manufacturers, labelers, and
23 providers may recover in the normal course of their respective businesses without
24 time limitation assessments or provider payment rate adjustments used to recoup
25 any deficit incurred under the plan.

BILL

1 **SECTION 54.** 149.143 (4) of the statutes is amended to read:

2 149.143 (4) Using the procedure under s. 227.24, the department board may
3 promulgate rules under sub. (2) or (3) for the period before the effective date of any
4 permanent rules promulgated under sub. (2) or (3), but not to exceed the period
5 authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the
6 department board is not required to make a finding of emergency.

7 **SECTION 55.** 149.143 (4) of the statutes, as affected by 2003 Wisconsin Act ...
8 (this act), is amended to read:

9 149.143 (4) Using the procedure under s. 227.24, the board may promulgate
10 rules under sub. (2) ~~or~~, (3), or (3c) or s. 149.144 for the period before the effective date
11 of any permanent rules promulgated under sub. (2) ~~or~~, (3), or (3c) or s. 149.144, but
12 not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding
13 s. 227.24 (1) and (3), the board is not required to make a finding of emergency.

14 **SECTION 56.** 149.143 (5) (a) of the statutes is amended to read:

15 149.143 (5) (a) Annually, no later than April 30, the department board shall
16 perform a reconciliation with respect to plan costs, premiums, insurer assessments,
17 and provider payment rate adjustments based on data from the previous calendar
18 year. On the basis of the reconciliation, the department board shall make any
19 necessary adjustments in premiums, insurer assessments, or provider payment
20 rates, subject to s. 149.142 (1) (b), for the fiscal year beginning on the first July 1 after
21 the reconciliation, as provided in sub. (2) (b). The board shall consult with the
22 department as necessary in performing the reconciliation and in making the
23 adjustments under this paragraph.

24 **SECTION 57.** 149.143 (5) (a) of the statutes, as affected by 2003 Wisconsin Act
25 (this act), is amended to read:

BILL

1 149.143 (5) (a) Annually, no later than April 30, the board shall perform a
2 reconciliation with respect to plan costs, premiums, insurer assessments,
3 manufacturer and labeler assessments, and provider payment rate adjustments
4 based on data from the previous calendar year. On the basis of the reconciliation, the
5 board shall make any necessary adjustments in premiums, insurer assessments,
6 manufacturer and labeler assessments, or provider payment rates, subject to s.
7 149.142 (1) (b), for the fiscal year beginning on the first July 1 after the reconciliation,
8 as provided in sub. (2) (b). The board shall consult with the department as necessary
9 in performing the reconciliation and in making the adjustments under this
10 paragraph.

11 **SECTION 58.** 149.143 (5) (b) of the statutes is amended to read:

12 149.143 (5) (b) Except as provided in sub. (3) and s. 149.144, the department
13 board shall adjust the provider payment rates to meet the providers' specified portion
14 of the plan costs no more than once annually, subject to s. 149.142 (1) (b). The
15 department board may not determine the adjustment on an individual provider basis
16 or on the basis of provider type, but shall determine the adjustment for all providers
17 in the aggregate, subject to s. 149.142 (1) (b).

18 **SECTION 59.** 149.144 of the statutes, as affected by 2003 Wisconsin Act 33, is
19 amended to read:

20 **149.144 Adjustments to insurer assessments and provider payment**
21 **rates for premium, deductible, and prescription drug copayment**
22 **reductions.** The department board shall, by rule, adjust in equal proportions the
23 amount of the ~~assessment~~ assessments set under s. 149.143 (2) (a) 3. and the provider
24 payment rate set under s. 149.143 (2) (a) 4., subject to ss. 149.142 (1) (b) and 149.143
25 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165

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1 (2) and (3), deductible reductions under s. 149.14 (5) (a), and any prescription drug
2 copayment reductions under s. 149.14 (5) (e). The ~~department~~ board shall notify the
3 commissioner so that the commissioner may levy any increase in insurer
4 assessments.

5 **SECTION 60.** 149.144 of the statutes, as affected by 2003 Wisconsin Act (this
6 act), is amended to read:

7 **149.144 Adjustments to insurer assessments and provider payment**
8 **rates for premium, deductible, and prescription drug copayment**
9 **reductions.** The board shall, by rule, adjust in equal proportions the ~~amount~~
10 amounts of the assessments set under s. 149.143 (2) (a) 3. and 3m. and the provider
11 payment rate set under s. 149.143 (2) (a) 4., subject to ss. 149.142 (1) (b) and 149.143
12 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165
13 (2) and (3), deductible reductions under s. 149.14 (5) (a), and any prescription drug
14 copayment reductions under s. 149.14 (5) (e). The board shall notify the
15 commissioner and the department so that the commissioner may levy any increase
16 in insurer assessments and the department may levy any increase in manufacturer
17 and labeler assessments. If the board determines that the insurer assessments,
18 manufacturer and labeler assessments, and provider payment rates may not be
19 adjusted in equal proportions to reimburse the plan for premium, deductible, and
20 prescription drug copayment reductions, the board shall adjust the insurer
21 assessments and provider payment rate in equal proportions to reimburse the plan
22 for those reductions.

23 **SECTION 61.** 149.145 of the statutes, as affected by 2003 Wisconsin Act 33, is
24 amended to read:

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1 **149.145 Program budget.** ~~The department, in consultation with the board,~~
2 shall establish a program budget for each plan year. The program budget shall be
3 based on the provider payment rates specified in s. 149.142 and in the most recent
4 provider contracts that are in effect and on the funding sources specified in ss.
5 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143,
6 149.144, and 149.146 for determining premium rates, insurer assessments, and
7 provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b)
8 and subject to s. 149.142 (1) (b), from the program budget ~~the department~~ board shall
9 derive the actual provider payment rate for a plan year that reflects the providers'
10 proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The
11 ~~department may not implement a program budget established under this section~~
12 ~~unless it is approved by the board~~ shall consult with the department as necessary in
13 deriving the actual provider payment rate.

14 **SECTION 62.** 149.145 of the statutes, as affected by 2003 Wisconsin Act (this
15 act), is amended to read:

16 **149.145 Program budget.** The board shall establish a program budget for
17 each plan year. The program budget shall be based on the provider payment rates
18 specified in s. 149.142 and in the most recent provider contracts that are in effect and
19 on the funding sources specified in ss. 149.143 (1) and 149.144, including the
20 methodologies specified in ss. 149.143, 149.144, and 149.146 for determining
21 premium rates, insurer and manufacturer and labeler assessments, and provider
22 payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject
23 to s. 149.142 (1) (b), from the program budget the board shall derive the actual
24 provider payment rate for a plan year that reflects the providers' proportional share

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1 of the plan costs, consistent with ss. 149.143 and 149.144. The board shall consult
2 with the department as necessary in deriving the actual provider payment rate.

3 **SECTION 63.** 149.146 (1) (b) of the statutes is amended to read:

4 149.146 (1) (b) An eligible person under par. (a) may elect once each year, at
5 the time and according to procedures established by the ~~department~~ board, among
6 the coverages offered under this section and s. 149.14. If an eligible person elects new
7 coverage, any preexisting condition exclusion imposed under the new coverage is met
8 to the extent that the eligible person has been previously and continuously covered
9 under this chapter. No preexisting condition exclusion may be imposed on an eligible
10 person who elects new coverage if the person was an eligible individual when first
11 covered under this chapter and the person remained continuously covered under this
12 chapter up to the time of electing the new coverage.

13 **SECTION 64.** 149.146 (2) (a) of the statutes, as affected by 2003 Wisconsin Act
14 33, is amended to read:

15 149.146 (2) (a) Except as specified by the ~~department~~ board, the terms of
16 coverage under s. 149.14, including deductible reductions under s. 149.14 (5) (a) and
17 prescription drug copayment reductions under s. 149.14 (5) (e), do not apply to the
18 coverage offered under this section. Premium reductions under s. 149.165 do not
19 apply to the coverage offered under this section.

20 **SECTION 65.** 149.146 (2) (am) 4. of the statutes is amended to read:

21 149.146 (2) (am) 4. Notwithstanding subs. 1. to 3., the ~~department~~ board may
22 establish different deductible amounts, a different coinsurance percentage, and
23 different covered costs and deductible aggregate amounts from those specified in
24 subs. 1. to 3. in accordance with cost containment provisions established by the
25 ~~department~~ board under s. 149.17 (4).

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1 **SECTION 66.** 149.146 (2) (am) 5. of the statutes is amended to read:

2 149.146 (2) (am) 5. Subject to s. 149.14 (8) (b), the department board may, by
3 rule under s. 149.17 (4), establish for prescription drug coverage under this section
4 copayment amounts, coinsurance rates, and copayment and coinsurance
5 out-of-pocket limits over which the plan will pay 100% of covered costs for
6 prescription drugs. ~~Any copayment amount, coinsurance rate, or out-of-pocket~~
7 ~~limit established under this subdivision is subject to the approval of the board.~~
8 Copayments and coinsurance paid by an eligible person under this subdivision are
9 separate from and do not count toward the deductible and covered costs not paid by
10 the plan under subs. 1. to 3.

11 **SECTION 67.** 149.146 (2) (b) (intro.) of the statutes is amended to read:

12 149.146 (2) (b) (intro.) The schedule of premiums for coverage under this
13 section shall be promulgated by rule by the department board, as provided in s.
14 149.143. The rates for coverage under this section shall be set such that they differ
15 from the rates for coverage under s. 149.14 (2) (a) by the same percentage as the
16 percentage difference between the following:

17 **SECTION 68.** 149.146 (2) (b) 1. of the statutes is amended to read:

18 149.146 (2) (b) 1. The rate that a standard risk would be charged under an
19 individual policy providing substantially the same coverage and ~~deductibles~~
20 ~~cost-sharing provisions~~ as provided under s. 149.14 (2) (a) and (5) (a).

21 **SECTION 69.** 149.146 (2) (b) 2. of the statutes is amended to read:

22 149.146 (2) (b) 2. The rate that a standard risk would be charged under an
23 individual policy providing substantially the same coverage and ~~deductibles~~
24 ~~cost-sharing provisions~~ as the coverage offered under this section.

25 **SECTION 70.** 149.15 (1) of the statutes is amended to read:

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1 149.15 (1) The plan shall ~~have~~ operate under the direction of a board of
2 governors consisting of representatives of 2 participating insurers that are nonprofit
3 corporations, representatives of 2 other participating insurers, 3 4 health care
4 ~~provider~~ industry representatives, including one representative of the ~~State~~
5 Wisconsin Medical Society of Wisconsin, one representative of the Wisconsin Health
6 and Hospital Association, one representative of Pharmaceutical Research and
7 Manufacturers of America, and one representative of an integrated
8 multidisciplinary health system, and 4 public members, including one
9 representative of small businesses in the state, appointed by the secretary for
10 staggered 3-year terms. In addition, the commissioner, or a designated
11 representative from the office of the commissioner, and the secretary, or a designated
12 representative from the department, shall be members of the board. The public
13 members shall not be professionally affiliated with the practice of medicine, a
14 hospital, or an insurer. At least one of the public members shall be an individual who
15 has coverage under the plan. ~~The secretary or the secretary's representative shall~~
16 be board annually shall select the chairperson of the board. Board members, except
17 the commissioner or the commissioner's representative and the secretary or the
18 secretary's representative, shall be compensated at the rate of \$50 per diem plus
19 actual and necessary expenses.

20 **SECTION 71.** 149.15 (3) (b) of the statutes is created to read:

21 149.15 (3) (b) Establish by rule the plan design, including covered benefits and
22 exclusions. At least every 3 years, the board shall conduct a survey of health care
23 plans available in the private market and make any adjustments to the plan that the
24 board determines are advisable on the basis of the survey. Using the procedure under
25 s. 227.24, the board may promulgate rules under this paragraph for the period before

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1 the effective date of any permanent rules promulgated under this paragraph, but not
2 to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s.
3 227.24 (1) and (3), the board is not required to make a finding of emergency.

4 **SECTION 72.** 149.15 (3) (c) of the statutes is repealed.

5 **SECTION 73.** 149.15 (3) (e) of the statutes is created to read:

6 149.15 (3) (e) Select a plan administrator in a competitive,
7 request-for-proposals process and enter into a contract with the person selected.

8 **SECTION 74.** 149.15 (3) (~~a~~)⁴ of the statutes is created to read:

9 149.15 (3) (~~a~~)^c Contract with persons to provide professional services to the
10 board and the plan.

11 **SECTION 75.** 149.15 (3) (f) of the statutes is repealed.

12 **SECTION 76.** 149.15 (4) (~~a~~)^d of the statutes is created to read:

13 149.15 (4) (~~a~~)^d Notwithstanding ss. 625.11 (4) and 628.34 (3) (a) and any
14 requirements in this chapter related to setting premium rates or amounts, establish
15 for eligible persons with household incomes that exceed \$100,000 a separate
16 schedule of premium rates that are higher than the rates set for other eligible
17 persons. Premium rates established under this paragraph may not exceed 200% of
18 the rate that a standard risk would be charged under an individual policy providing
19 substantially the same coverage and ~~deductibles~~ that are provided under the plan.
20 The board shall use excess premiums collected under a schedule established under
21 this paragraph to reduce premiums for eligible persons with low household incomes,
22 as determined by the board. Household income under this paragraph shall be
23 determined in the same manner as household income is determined under s. 149.165
24 (2) and (3).

25 **SECTION 77.** 149.15 (5) of the statutes is repealed.

Cost-sharing provisions

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1 **SECTION 78.** 149.16 of the statutes, as affected by 2003 Wisconsin Act 33, is
2 repealed.

3 **SECTION 79.** 149.165 (1) of the statutes is amended to read:

4 149.165 (1) Except as provided in s. 149.146 (2) (a), the ~~department~~ board shall
5 reduce the premiums established under ~~s. 149.11~~ in conformity with ss. 149.14 (5m),
6 149.143, and 149.17 for the eligible persons and in the manner set forth in subs. (2)
7 and (3).

8 **SECTION 80.** 149.165 (2) of the statutes is amended to read:

9 149.165 (2) (a) Subject to ~~sub.~~ subs. (3m) and (3r), if the household income, as
10 defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with
11 coverage under s. 149.14 (2) (a) is equal to or greater than the first amount and less
12 than the 2nd amount listed in any of the following, the ~~department~~ board shall
13 reduce the premium for the eligible person to the rate shown after the amounts:

14 1. If equal to or greater than \$0 and less than \$10,000, to 100% of the rate that
15 a standard risk would be charged under an individual policy providing substantially
16 the same coverage and ~~deductibles~~ cost-sharing provisions as provided under s.
17 149.14 (2) (a) and (5) (~~a~~).

18 2. If equal to or greater than \$10,000 and less than \$14,000, to 106.5% of the
19 rate that a standard risk would be charged under an individual policy providing
20 substantially the same coverage and ~~deductibles~~ cost-sharing provisions as
21 provided under s. 149.14 (2) (a) and (5) (~~a~~).

22 3. If equal to or greater than \$14,000 and less than \$17,000, to 115.5% of the
23 rate that a standard risk would be charged under an individual policy providing
24 substantially the same coverage and ~~deductibles~~ cost-sharing provisions as
25 provided under s. 149.14 (2) (a) and (5) (~~a~~).

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1 4. If equal to or greater than \$17,000 and less than \$20,000, to 124.5% of the
2 rate that a standard risk would be charged under an individual policy providing
3 substantially the same coverage and deductibles cost-sharing provisions as
4 provided under s. 149.14 (2) (a) and (5) (a).

5 5. If equal to or greater than \$20,000 and less than \$25,000, to 130% of the rate
6 that a standard risk would be charged under an individual policy providing
7 substantially the same coverage and deductibles cost-sharing provisions as
8 provided under s. 149.14 (2) (a) and (5) (a).

9 (bc) Subject to ~~sub.~~ subs. (3m) and (3r), if the household income, as defined in
10 s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage
11 under s. 149.14 (2) (b) is equal to or greater than the first amount and less than the
12 2nd amount listed in par. (a) 1., 2., 3., 4., or 5., the ~~department~~ board shall reduce the
13 premium established for the eligible person by the same percentage as the
14 ~~department~~ board reduces, under par. (a), the premium established for an eligible
15 person with coverage under s. 149.14 (2) (a) who has a household income specified
16 in the same subdivision under par. (a) as the household income of the eligible person
17 with coverage under s. 149.14 (2) (b).

18 **SECTION 81.** 149.165 (3) (a) of the statutes is amended to read:

19 149.165 (3) (a) Subject to par. (b), the ~~department~~ board shall establish and
20 implement the method for determining the household income of an eligible person
21 under sub. (2).

22 **SECTION 82.** 149.165 (3) (b) (intro.) of the statutes is amended to read:

23 149.165 (3) (b) (intro.) In determining household income under sub. (2), the
24 ~~department~~ board shall consider information submitted by an eligible person on a

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1 completed federal profit or loss from farming form, schedule F, if all of the following
2 apply:

3 **SECTION 83.** 149.165 (3r) of the statutes is created to read:

4 149.165 (3r) The board shall use any excess premiums collected under a
5 schedule established under s. 149.15 (4) ^{(d) ✓} to further reduce the premium rates under
6 sub. (2) (a) 1. to 5. and (bc).

7 **SECTION 84.** 149.17 (4) of the statutes is amended to read:

8 149.17 (4) Cost containment provisions established by the ~~department~~ board
9 by rule, including managed care requirements.

10 **SECTION 85.** 149.175 of the statutes is amended to read:

11 **149.175 Waiver or exemption from provisions prohibited.** Except as
12 provided in ^{ss.} s. 149.13 (1) ^{→ and 149.132(1)(b) ✓}, the department or the board may not waive, or authorize
13 ~~the board to waive~~, any of the requirements of this chapter or exempt, or authorize
14 ~~the board to exempt~~, an individual or a class of individuals from any of the
15 requirements of this chapter.

16 **SECTION 86.** 149.20 of the statutes is amended to read:

17 **149.20 ~~Rule-making in consultation with~~ Rules to be approved by**
18 **board.** In ~~promulgating any~~ Any rules proposed by the department under this
19 chapter, ~~the department shall consult with~~ may not be promulgated without the
20 approval of the board.

21 **SECTION 87.** 149.25 (2) (a) of the statutes is amended to read:

22 149.25 (2) (a) The department shall conduct a 3-year pilot program, beginning
23 on July 1, 2002, under which eligible persons who qualify under par. (b) are provided
24 community-based case management services. The department shall consult with
25 the board as necessary in conducting the pilot program.

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1 **SECTION 88.** 149.25 (4) of the statutes is amended to read:

2 149.25 (4) **EVALUATION STUDY.** The department, in consultation with the board,
3 shall conduct a study that evaluates the pilot program in terms of health care
4 outcomes and cost avoidance. In the study, the department shall measure and
5 compare, for pilot program participants and similarly situated eligible persons not
6 participating in the pilot program, plan costs and utilization of services, including
7 inpatient hospital days, rates of hospital readmission within 30 days for the same
8 diagnosis, and prescription drug utilization. The department shall submit a report
9 on the results of the study, including the department's conclusions and
10 recommendations, to the legislature under s. 13.172 (2) and to the governor.

11 **SECTION 89.** 450.10 (2m) of the statutes is created to read:

12 450.10 (2m) If a manufacturer or labeler fails to pay an assessment levied
13 under s. 149.132 (3) within the time required for payment, the board may assess a
14 forfeiture of not more than \$1,000 for each day that the payment is past due.

15 **SECTION 90. Nonstatutory provisions.**

16 (1) **FEDERAL GRANT FUNDS.** Notwithstanding section 149.143 (1) of the statutes,
17 as affected by this act, any federal grant moneys received by the state under the
18 Trade Adjustment Assistance Reform Act of 2002 and allocated to the Health
19 Insurance Risk-Sharing Plan shall be used to pay plan costs before any moneys
20 specified under section 149.143 (1) (am) and (bm) of the statutes, as affected by this
21 act, are used. After the federal grant money has been used, plan costs shall be paid
22 as provided under section 149.143 (1) (am) and (bm) of the statutes, as affected by
23 this act.

24 (2) **SELECTION OF PLAN ADMINISTRATOR.** The board of governors of the Health
25 Insurance Risk-Sharing Plan shall, no later than ~~December 31, 2009~~ issue a

July 1, 2004

BILL

1 request-for-proposals under section 149.15 (3) (e) of the statutes, as created by this
2 act, for administration of the Health Insurance Risk-Sharing Plan.

SECTION 91. Initial applicability.

3
4 (1) DESIGN. With respect to changes in plan design, including covered expenses
5 and exclusions, deductibles, copayments, coinsurance, and out-of-pocket limits, the
6 treatment of sections 149.11, 149.14 (3) (intro.) and (a) to (r), (4), (5) (d) and (e), and
7 (8), 149.146 (1) (b) and (2) (a), (am) 4. and 5., and (b) (intro.) and 1., 149.15 (3) (b), and
8 149.17 (4) of the statutes first applies to the plan year beginning on January 1, 2005.

9 (2) ELIGIBILITY. The treatment of section 149.12 (1) (a), (am), (b), and (c) of the
10 statutes first applies to applications for coverage under the Health Insurance
11 Risk-Sharing Plan that are received on the effective date of this subsection.

12 **SECTION 92. Effective dates.** This act takes effect on the day after publication,
13 except as follows:

14 (1) ELIGIBILITY. The treatment of section 149.12 (1) (a), (am), (b), and (c) of the
15 statutes and SECTION 91 (2) of this act take effect on the first day of the 4th month
16 beginning after publication.

17 (2) DRUG MANUFACTURER AND LABELER ASSESSMENTS. The treatment of sections
18 25.55 (3), 149.10 (5f) and (5r), 149.132, 149.143 (1) (intro.) (by SECTION 30), (am) 4.,
19 and (bm) 1., 1m., and 2., (2) (a) 3m. and 4. and (b) (by SECTION 42), (3) (a) (by SECTION
20 49) and (b) (by SECTION 51), (3c), (3m), (4) (by SECTION 55), and (5) (a) (by SECTION 57),
21 149.144 (by SECTION 60), 149.145 (by SECTION 62), and 450.10 (2m) of the statutes
22 takes effect on July 1, 2004.

23 (END)

Kahler, Pam

From: Sweet, Richard
Sent: Thursday, January 15, 2004 5:15 PM
To: Kahler, Pam
Cc: Thorson, Randy; Carabell, Rachel; Swissdorf, Kim
Subject: Heads-up on HIRSP

Pam,

I just wanted to let you know that the HIRSP group met again today and they are closing in on a revised draft. To date, they have agreed to replace the 1/3, 1/3, 1/3 split of the 40% with a different formula. Drug manufacturers and labelers would be required to pay an assessment to HIRSP as a condition of having their drugs covered under the program. (This would presumably replace the language on page 8 of LRB-2476/3 and also alter the language on page 14.)

The amount of the assessment would be 18% of "ingredient costs". This is a term I haven't heard before and Mark Moody said you could call Russ Pederson of DHFS for more information on this. Rachel Carabell said that it is what MA pays, not including the dispensing fee, so maybe you could tie the new language to that. The 18% would be based on what each manufacturer or labeler provided to HIRSP enrollees (probably in the state fiscal year preceding the calendar year to which the assessment applies, although the group didn't discuss timing).

After accounting for the premiums received from enrollees (60%), the amounts received from the new drug assessment would be subtracted from the remaining 40%. After this subtraction, insurers and health care providers would split the difference as they do now.

There is an existing contract with a PBM that expires next year, so you may want to add a nonstatutory provision that says this doesn't take effect until after expiration of the contract if the bill conflicts with the contract.

Gregg Underheim would like to have a committee meeting on the new draft in mid-February and would like a draft by the first few days in February so that it can be reviewed by the group and then distributed. There may be some other changes coming, but I wanted to let you know about this one. I should be able to tell you more by the end of next week.

I also cc'ed Randy in Gregg's office and Rachel and Kim in the Fiscal Bureau in case you have questions.

Thanks for your help.

Dick Sweet

Senior Staff Attorney

Wisconsin Legislative Council

(608)266-2982

richard.sweet@legis.state.wi.us

Kahler, Pam

From: Sweet, Richard
Sent: Wednesday, January 21, 2004 10:07 AM
To: Kahler, Pam
Subject: dhfs



dhfs.pdf

Pam,

The LFB summary of the budget uses the term "average wholesale price" or AWP to describe what MA reimburses pharmacies (e.g. AWP minus 12%). See page 378, which is page 50 on the scroll bar. But it looks like ch. 49, Stats. doesn't use these terms. I wonder if you could just reference "18% of the reimbursement rate for prescription drugs under medical assistance, not including dispensing fees".

Dick

6. SENIORCARE -- LONG-TERM CARE INSURANCE AND SPENDDOWN REQUIREMENT

Joint Finance/Legislature: Permit SeniorCare enrollees that are required to spend down their income to 240% of the federal poverty level (FPL) before being eligible to receive SeniorCare benefits, to count premiums paid for long-term care insurance towards their spenddown requirement. Premium payments would not be counted towards the individual's deductible requirement. This provision would first apply to enrollees with 12-month benefit periods that begin starting September 1, 2003, or the first day of the first month after the bill's general effective date, whichever is later.

Currently, only drugs purchased by an individual at retail prices count towards a spenddown requirement. Once an enrollee spends down to 240% of the FPL, the enrollee must pay an annual deductible before the state makes payments for drugs purchased for the enrollee. Currently, that deductible is \$500 annually. Under the bill, the annual deductible would increase to \$850. In 2003, 240% of the FPL for one person is equal to \$21,552 annually and \$29,088 annually for two people.

Veto by Governor [C-15]: Delete provision.

[Act 33 Vetoed Sections: 1438h, 1445h, 1446h, and 9324(13d)]

7. MA PAYMENTS -- PRESCRIPTION DRUG REIMBURSEMENT RATES [LFB Paper 389]

	Governor (Chg. to Base)	Jt. Finance /Leg. (Chg. to Gov)	Veto (Chg. to Leg)	Net Change
GPR	-\$26,588,200	\$22,500,600	-\$3,044,200	-\$7,131,800
FED	- 30,291,700	25,188,200	- 3,781,400	- 8,884,900
PR	- 3,444,200	3,372,700	- 19,300	- 90,800
Total	-\$60,324,100	\$51,061,500	-\$6,844,900	-\$16,107,500

Governor: Reduce MA, BadgerCare, and SeniorCare benefits funding by \$27,556,500 (-\$12,085,900 GPR, -\$13,989,600 FED, and -\$1,481,000 PR) in 2003-04 and by \$32,767,600 (-\$14,502,300 GPR, -\$16,302,100 FED, and -\$1,963,200 PR) in 2004-05 to reflect projected savings that would result by reducing the MA reimbursement rate DHFS pays to pharmacies and pharmacists for brand name and non-readily available generic prescription drugs and the reimbursement rate paid to providers under SeniorCare.

Under this item, DHFS would reimburse pharmacies and pharmacists for these drugs at a rate equal to the average wholesale price (AWP), as reported by manufacturers, minus 15%, plus the applicable dispensing fee (currently \$4.88 for most drugs). DHFS currently pays pharmacies and pharmacists a rate equal to the AWP minus 11.25%, plus a dispensing fee, for these types of drugs. DHFS would continue to pay pharmacies and pharmacists for readily available prescription drugs a rate equal to the maximum allowable cost, which is determined by DHFS, plus the applicable dispensing fee.

Kahler, Pam

From: Pederson, Russell
Sent: Wednesday, January 21, 2004 12:01 PM
To: Kahler, Pam
Subject: Ingredient Cost Reimbursement

Pam,

Here is the language from the Pharmacy Handbook:

Ingredient Cost Reimbursement

Legend Drugs

Some covered legend drugs are reimbursed at either the drug's Average Wholesale Price (AWP) minus 12% plus a dispensing fee, or the provider's usual and customary charge, whichever is less. Other legend drugs are reimbursed at either the drug's price on the Medicaid Maximum Allowed Cost (MAC) List plus a dispensing fee or the provider's usual and customary charge, whichever is less.

Refer to the Pharmacy Data Tables section of this handbook for the Legend Drug MAC List and the OTC Drug MAC List.

Wisconsin Medicaid reimburses providers for an innovator drug at the same rate that it reimburses for the generic equivalent of the drug if it is on the MAC List, unless the "Brand Medically Necessary" prescription requirements are met. This policy is required by HFS 107.10, Wis. Admin. Code (PDF), and by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) revisions to Title XIX of the Social Security Act.

Over-the-Counter Drugs

The estimated acquisition cost for covered OTC drugs is determined by applying a 12% discount to the AWP as listed by First DataBank, except for MAC drugs.

Refer to the Covered Drugs and Services chapter and Appendix 5 of this section for information on Medicaid coverage of OTC drugs. To request an addition of National Drug Codes for unlisted OTCs, complete Appendix 1 of this section.

Dispensing Fee Reimbursement

Wisconsin Medicaid reimburses different dispensing fees depending on the service provided. These fees include the following:

Traditional dispensing fee.

Compound drug dispensing fee.

Pharmaceutical Care (PC) dispensing fee.

Refer to Appendix 7 of this section for the pharmacy dispensing fee schedule.

Traditional Dispensing Fee

A traditional dispensing fee is usually paid once per recipient, per service, per month, per provider, dependent on the physician's prescription. Refer to the Pharmaceutical Procedures chapter of this section for a list of unacceptable practices

Let me know if you need any additional information. Thanks,

Russ

Russell Pederson, Chief
Hospital, Physician, Clinic and Pharmacy Section
Division of Health Care Financing

Wisconsin Department of Health and Family Services
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fax 608/266-1096
pederrj@dhfs.state.wi.us

* * * * *

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* * * * *

ingredient cost = MA reimb rate, whatever that happens to be?

ingredient cost = AWP (of all drugs)

how

are drugs obtained from pharmacies?

is MA reimb rate = that or rates anywhere?

cost = 18% of AWP of all drugs provided to HIRSP enrollees - 13%

ingredient cost = AWP (of a drug) - %

18% of ingredient cost = AWP minus the amount for all working

Can they determine which drugs were sold to HIRSP?

Kahler, Pam

From: Sweet, Richard
Sent: Wednesday, January 28, 2004 2:01 PM
To: Kahler, Pam
Subject: RE: HIRSP draft

You might want to call Randy and see if there is more. I think the only item left on the table (that Mark Moody of DHFS was going to get back to us on) was a study or report on privatizing HIRSP.

-----Original Message-----

From: Kahler, Pam
Sent: Wednesday, January 28, 2004 1:27 PM
To: Sweet, Richard
Subject: RE: HIRSP draft

Thanks. Assuming that I do not have all of the changes yet, then, I'm not going to get another version out until I hear otherwise - unless you think this is all there is.....

-----Original Message-----

From: Sweet, Richard
Sent: Wednesday, January 28, 2004 1:24 PM
To: Kahler, Pam
Subject: RE: HIRSP draft

I haven't heard anything on it. I did speak with Randy about "rebate" vs. "assessment" and he and Gregg agreed that "rebate" was a more accurate description.

-----Original Message-----

From: Kahler, Pam
Sent: Tuesday, January 27, 2004 10:41 AM
To: Sweet, Richard
Subject: RE: HIRSP draft

Hi, Dick:

Any word yet on whether there will be any more changes for the HIRSP bill? FYI, Randy said to use "rebate" rather than "assessment." Thanks.

Pam

-----Original Message-----

From: Sweet, Richard
Sent: Monday, January 26, 2004 9:34 AM
To: Kahler, Pam
Subject: RE: HIRSP draft

Pam,

Rachel told me that currently assessments are usually calculated around April for the coming fiscal year. The plan administrator should know by then how much of each company's drugs were sold in the previous calendar year. They could let the board and the companies know these amounts.

On the issue of assessments vs. rebates, the group referred to these as assessments, although they seem a lot like the rebates that are given to MA. You may want to check with Gregg to see what his preference is.

Dick

-----Original Message-----

From: Kahler, Pam
Sent: Friday, January 23, 2004 1:08 PM
To: Sweet, Richard
Subject: RE: HIRSP draft

Dick:

How are drug manufacturers and labelers supposed to find out the amount that they must pay 20% of? Does DHFS, the plan administrator, or the board figure out the amount and let each one know? Isn't there a rebate currently? How does that work? In the draft, the board could just determine the mechanism for collecting the amount. Does that seem like the best way to go? When I spoke with Rachel, she thought it would be better to call it a rebate than an assessment. Is there any problem with that? Thanks!

Pam

-----Original Message-----

From: Sweet, Richard
Sent: Thursday, January 22, 2004 2:36 PM
To: Kahler, Pam
Cc: Thorson, Randy; Carabell, Rachel; Swissdorf, Kim
Subject: HIRSP draft

Pam:

I spoke with Randy from Gregg Underheim's office after speaking with Rachel on the HIRSP drug assessment issue. What Rachel and I discussed, and Randy verified that Gregg wants, is to have an assessment on each drug manufacturer and labeler whose drugs are covered under HIRSP, as a condition of having their drugs covered. The assessment would be 20% of what HIRSP reimbursed pharmacies for the manufacturer's or labeler's drugs in the previous calendar year (including the dispensing fee). Rachel indicated that this would be approximately what the drug rebate is under MA.

Thanks for your help.

Dick

Kahler, Pam

From: Thorson, Randy
Sent: Monday, January 26, 2004 2:00 PM
To: Kahler, Pam
Subject: RE: HIRSP draft

Pam,

Please use the term rebate. Accuracy is a good thing.

Randy Thorson
Research Assistant to
Gregg Underheim
State Representative
54th Assembly District

-----Original Message-----

From: Kahler, Pam
Sent: Monday, January 26, 2004 11:21 AM
To: Thorson, Randy
Subject: HIRSP draft

Hi, Randy:

I have a question for you about the payment that drug manufacturers must make. We (and the group working on this in general) have been calling it an assessment, but Rachel Carabell (fiscal bureau) thinks it should be called a rebate. "Rebate" certainly seems to be a more accurate term than "assessment." Dick Sweet thought I should ask if Rep. Underheim has a preference for either term. Thanks.

Pam

1-30

per Dick Sweet:

(1) keep language on p. 8 re. name & labels that sell drugs to MA, Dodge Cars, etc., must sell to HIRSP

(2) add "condition" language, too

(3) make the assessment equal to MA rebate & base it on prior calendar year claims (no longer 20%)

(4) call it an "assessment" rather than a rebate

(5) keep penalty language

(6) per meeting w/ Dick Sweet, Rachel Carabell & Kim Swislday, must begin w/ claims paid on July 1, 2004

(current contracts run until then)

Memo

To: Senator

Representative

Under heim

(The Draft's Requester)

Per your request: ... the attached fiscal estimate was prepared for your un-introduced 2003 draft.

LRB Number: LRB

-2476

Version:

“ / 3 ”

Fiscal Estimate Prepared By: (agency abbr.)

DHFS

If you have questions about the enclosed fiscal estimate, you may contact the state agency representative that prepared the fiscal estimate. If you disagree with the enclosed fiscal estimate, please contact the LRB drafter of your proposal to discuss your options under the fiscal estimate procedure.

Entered In Computer And Copy Sent To Requester Via E-Mail:

12 / 18 / 2003

* * * * *

To: LRB – Legal Section PA's

Subject: *Fiscal Estimate Received For An Unintroduced Draft*

- > **If redrafted** ... please insert this cover sheet and attached early fiscal estimate into the drafting file ... after the draft's old version (the version that this fiscal estimate was based on), and before the markup of the draft on the updated version.
- > **If introduced** ... and the version of the attached fiscal estimate is for a **previous version** ... please insert this cover sheet and attached early fiscal estimate into the drafting file ... after the draft's old version (the version that this fiscal estimate was based on), and before the markup of the draft on the updated version. Have Mike (or Lynn) get the ball rolling on getting a fiscal estimate prepared for the introduced version.
- > **If introduced** ... and the version of the attached fiscal estimate is for the **current version** ... please write the draft's introduction number below and give to Mike (or Lynn) to process.

THIS DRAFT WAS INTRODUCED AS: 2003 _____

Barman, Mike

From: Barman, Mike
Sent: Thursday, December 18, 2003 9:18 AM
To: Rep.Underheim; Thorson, Randy
Subject: LRB 03-2476/3 (FE by DHFS - attached - for your review)



FE_Underheim.pdf

Fiscal Estimate - 2003 Session

Original Updated Corrected Supplemental

LRB Number 03-2476/3	Introduction Number	
Subject Modifications to HIRSP		
Fiscal Effect		
State: <input type="checkbox"/> No State Fiscal Effect <input type="checkbox"/> Indeterminate <input checked="" type="checkbox"/> Increase Existing Appropriations <input type="checkbox"/> Increase Existing Revenues <input type="checkbox"/> Increase Costs - May be possible to absorb within agency's budget <input type="checkbox"/> Decrease Existing Appropriations <input type="checkbox"/> Decrease Existing Revenues <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Create New Appropriations <input type="checkbox"/> Decrease Costs		
Local: <input type="checkbox"/> No Local Government Costs <input type="checkbox"/> Indeterminate 1. <input type="checkbox"/> Increase Costs 3. <input type="checkbox"/> Increase Revenue 5. Types of Local Government Units Affected <input type="checkbox"/> Permissive <input type="checkbox"/> Mandatory <input type="checkbox"/> Permissive <input type="checkbox"/> Mandatory <input type="checkbox"/> Towns <input type="checkbox"/> Village <input type="checkbox"/> Cities 2. <input type="checkbox"/> Decrease Costs 4. <input type="checkbox"/> Decrease Revenue <input type="checkbox"/> Counties <input type="checkbox"/> Others <input type="checkbox"/> Permissive <input type="checkbox"/> Mandatory <input type="checkbox"/> Permissive <input type="checkbox"/> Mandatory <input type="checkbox"/> School Districts <input type="checkbox"/> WTCS Districts		
Fund Sources Affected Affected Ch. 20 Appropriations <input type="checkbox"/> GPR <input type="checkbox"/> FED <input type="checkbox"/> PRO <input type="checkbox"/> PRS <input checked="" type="checkbox"/> SEG <input type="checkbox"/> SEGS 20.435 (4)(u), 20.435 (4)(v)		
Agency/Prepared By DHFS/ Curtis Cunningham (608) 266-5362	Authorized Signature Freda Ellen Bove (608) 266-2907	Date 12/17/2003

Fiscal Estimate Narratives

DHFS 12/18/2003

LRB Number	03-2476/3	Introduction Number	Estimate Type	Original
Subject				
Modifications to HIRSP				

Assumptions Used in Arriving at Fiscal Estimate

The Health Insurance Risk-Sharing Plan (HIRSP) provides major medical health insurance coverage to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market. To qualify for HIRSP an individual must lose their employer sponsored health insurance or receive a notice of rejection of coverage from one or more insurers, a notice of cancellation from one or more insurers, or a notice of limitation of coverage from one or more insurers that substantially reduces coverage compared to the coverage available to a person considered a standard risk for the type of coverage. HIRSP program costs are financed 60% from policyholder premiums, 20% from assessments on insurance companies doing business in Wisconsin, and 20% from provider reimbursement discounts. Also, insurers/providers subsidize premiums and deductibles for policyholders with annual household incomes under \$25,000 and \$20,000 respectively. Currently the coverage guidelines are set in statute and the Department is responsible for administering the program in consultation with the HIRSP Board of Governors.

This legislation changes the HIRSP administrative structure, eligibility criteria, and funding. Administrative changes include transferring some of HIRSP's administrative authority to the HIRSP Board of Governors, giving the Board the authority to set coverage guidelines by administrative rule, adding a pharmacy representative to the Board, and requiring the Department to verify lack of employer insurance and collect economic and demographic data and issue quarterly reports. The eligibility criteria would require more than one rejection or cancellation of insurance coverage. HIRSP funding is altered by requiring drug manufacturers and labelers to pay a third of the 40% of plan costs now borne by insurers and providers and also contribute to one-third of the premium and deductible subsidies, requiring individuals with incomes over \$100,000 to pay 80% of the plan premium rates, and requiring any federal funding received from the Trade Adjustment Assistance Act of 2002 to be used to offset the costs of HIRSP as opposed to adding new categories of eligible persons.

Requiring pharmaceutical manufacturers and labelers to pay a third of the 40% of plan costs that providers and insurers are currently paying would reduce insurer and provider contributions to the HIRSP program. Total HIRSP expenditures in FY04 are estimated to be \$175 million with insurers and providers contributing \$36,596,798 each. Assuming a 15% increase in program costs, the budget for FY05 would be \$201.2 million with insurers and providers each contributing \$42,086,317 for a total of \$84,172,600. This legislation would require pharmaceutical manufacturers, insurers and providers to each contribute \$28,057,500 in FY05.

It is not possible to determine the fiscal impact of increasing eligibility criteria and giving the Board the authority to set coverage guidelines by administrative rule. The fiscal impact of these changes would depend on the policies implemented by the Board and how those policies would affect participation and benefit expenditures. It is unknown how much of a fiscal impact there would be to the Department for administrative costs since the Department still retains a number of administrative functions in addition to the Board. A preliminary analysis conducted by the federal Centers for Medicaid and Medicare Services estimated the fiscal impact of the federal Trade Adjustment Assistance Act of 2002 to be approximately \$2.8 million annually. Also, since the HIRSP program only collects income data for individuals that apply for premium and deductible subsidies, it is unknown how many enrollees have an income over \$100,000 and therefore would have to pay 80% of the premium costs. It is also unknown how many of these individuals would discontinue their participation in HIRSP due to the premium increase.

Requiring the Department to verify income and lack of employer insurance, collect economic and demographic data, and issue quarterly reports will increase HIRSP administrative costs. A precise fiscal estimate for these administrative duties will depend on how verification of income and lack of employer insurance is implemented. However, based on verification costs under Medicaid it is estimated that these requirements would increase HIRSP administrative costs by approximately \$250,000-\$500,000 per year.

Long-Range Fiscal Implications