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2003 SENATE BILL 466

February 13, 2004 − Introduced by Senators ROESSLER and SCHULTZ, cosponsored by Representatives UNDERHEIM, GIELOW, HAHN, TOWNSEND, BIES, MILLER, ALBERS, JOHNSRUD, BALOW, VAN ROY, SERATTI and MCCORMICK. Referred to Committee on Health, Children, Families, Aging and Long Term Care.

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

(3) (b) (intro.), 149.17 (4), 149.175, 149.20, 149.25 (2) (a) and 149.25 (4); and ***to create*** 149.10 (5f), 149.10 (5r), 149.125, 149.132, 149.142 (3), 149.143 (1) (bm) 1m., 149.143 (1) (bm) 2m. (intro.), 149.143 (2m) (c), 149.15 (3) (b), 149.15 (3) (e), 149.15 (4) (c), 149.15 (4) (d), 149.165 (3r) and 450.10 (2m) of the statutes; **relating to:** making various miscellaneous changes to the Health Insurance Risk−Sharing Plan, granting rule−making authority, and providing 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, any drug manufacturer or labeler that provides drugs prescribed for use by persons receiving benefits under Medical Assistance, BadgerCare, or SeniorCare is required to provide drugs prescribed for use by persons with coverage under HIRSP. As a condition of coverage of their prescription drugs under HIRSP, each manufacturer or labeler is required to pay an assessment that is based on the total claims paid by HIRSP in the previous calendar year to pharmacies and pharmacists for the manufacturer's or labeler's drugs. The assessment amount for each claim is equal to the rebate amount that the manufacturer or labeler pays for the drug under Medical Assistance. Under the bill, the 40 percent of HIRSP's operating costs that remain after premiums are used to pay 60 percent of the costs are first to be paid with the drug manufacturer and labeler assessments. The remainder of the 40 percent of the costs are paid, in equal proportions, by the health insurer assessments and the health care provider payment discounts. 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 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:

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

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

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

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

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

149.10 **(3)** "Eligible person" means a resident ~~of this state~~ who qualifies under s. 149.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

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

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

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

149.10 **(5r)** "Manufacturer" means a person engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) As a condition of coverage under the plan of the prescription drugs of a manufacturer or labeler, the manufacturer or labeler shall pay an assessment on the total claims that the plan paid, in the previous calendar year, to pharmacists and pharmacies for the prescription drugs of the manufacturer or labeler. The assessment amount per claim shall be equal to the rebate paid under the Medical Assistance program by the manufacturer or labeler for the prescription drug that is the subject of the claim.

(3) The plan administrator shall notify each manufacturer and each labeler of the amount paid by the plan in claims for the prescription drugs of each manufacturer and labeler and shall advise the board and the department of the amounts. The department shall levy and collect the assessments and deposit the amounts collected in the health insurance risk−sharing plan fund.

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

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

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

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

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

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

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

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

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

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

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

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

149.14 **(7)** (b) The ~~department~~ board has a cause of action against an eligible ~~participant~~ person for the recovery of the amount of benefits paid ~~which~~ that are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

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

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

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

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

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

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

(b) The payment rate for a prescription drug shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the ~~department~~ board may not reduce the payment rate for prescription drugs below

the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144.

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

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

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

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

SECTION 30. 149.143 (1) (am) of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.143 **(1)** (am) A total of ~~60%~~ 60 percent from the following sources, calculated as follows:

1. First, from premiums from eligible persons with coverage under s. 149.14 (2) (a) set at a rate that is ~~140%~~ 140 percent to ~~150%~~ 150 percent of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost−sharing provisions as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) set in accordance with s. 149.14 (5m), including amounts received for premium, deductible,

and prescription drug copayment subsidies under s. 149.144, and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

2. Second, from moneys specified under sub. (2m), to the extent that the amounts under subd. 1. are insufficient to pay ~~60%~~ 60 percent of plan costs.

3. Third, by increasing premiums from eligible persons with coverage under s. 149.14 (2) (a) to more than the rate at which premiums were set under subd. 1. but not more than ~~200%~~ 200 percent of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost−sharing provisions as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) by a comparable amount in accordance with s. 149.14 (5m), including amounts received for premium, deductible, and prescription drug copayment subsidies under s. 149.144, and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subds. 1. and 2. are insufficient to pay ~~60%~~ 60 percent of plan costs.

4. Fourth, notwithstanding par. (bm), by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subds. 1. to 3. are insufficient to pay ~~60%~~ 60 percent of plan costs.

SECTION 31. 149.143 (1) (bm) (intro.) of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.143 **(1)** (bm) (intro.) A total of ~~40%~~ 40 percent as follows:

SECTION 32. 149.143 (1) (bm) 1. of the statutes, as affected by 2003 Wisconsin Act 33, is renumbered 149.143 (1) (bm) 2m. a.

SECTION 33. 149.143 (1) (bm) 1m. of the statutes is created to read:

149.143 **(1)** (bm) 1m. First, from manufacturer and labeler assessments under s. 149.132.

SECTION 34. 149.143 (1) (bm) 2. of the statutes, as affected by 2003 Wisconsin Act 33, is renumbered 149.143 (1) (bm) 2m. b.

SECTION 35. 149.143 (1) (bm) 2m. (intro.) of the statutes is created to read:

149.143 **(1)** (bm) 2m. (intro.) The remainder as follows:

SECTION 36. 149.143 (2) (a) (intro.) of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

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

SECTION 37. 149.143 (2) (a) 1. a. of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.143 **(2)** (a) 1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium, deductible, and prescription drug copayment subsidies under s. 149.144 and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover ~~60%~~ 60 percent of the estimated plan costs for the new plan year.

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

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

SECTION 39. 149.143 (2) (a) 3. of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.143 **(2)** (a) 3. By rule, after estimating the amount of manufacturer and labeler assessments that will be received under sub. (1) (bm) 1m., set the total insurer assessments under s. 149.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) ~~1.~~ 2m. a. and notify the commissioner of the amount.

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

149.143 **(2)** (a) 4. By the same rule as under subd. 3., after estimating the amount of the manufacturer and labeler assessments that will be received under sub. (1) (bm) 1m., adjust the provider payment rate for the new plan year, subject to s. 149.142 (1) (b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) ~~2.~~ 2m. b. and as provided in s. 149.145.

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

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

SECTION 42. 149.143 (2m) (a) (intro.) of the statutes is amended to read:

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

SECTION 43. 149.143 (2m) (a) 2. of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.143 **(2m)** (a) 2. The amount of premiums, including amounts received for premium, deductible, and prescription drug copayment subsidies, necessary to cover ~~60%~~ 60 percent of the plan costs for the plan year.

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

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

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

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

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

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

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

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

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

149.143 **(3)** (a) If, during a plan year, the ~~department~~ board determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the ~~department~~ board may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (bm) 1., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. and s. 149.142 (1) (b).

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

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

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

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

SECTION 51. 149.143 (4) of the statutes is amended to read:

149.143 **(4)** Using the procedure under s. 227.24, the ~~department~~ board may promulgate rules under sub. (2) or (3) for the period before the effective date of any

permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the ~~department~~ board is not required to make a finding of emergency.

SECTION 52. 149.143 (5) (a) of the statutes is amended to read:

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

SECTION 53. 149.143 (5) (a) of the statutes, as affected by 2003 Wisconsin Act .... (this act), is amended to read:

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

SECTION 54. 149.143 (5) (b) of the statutes is amended to read:

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

SECTION 55. 149.144 of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.144 Adjustments to insurer assessments and provider payment rates for premium, deductible, and prescription drug copayment reductions. The ~~department~~ board shall, by rule, adjust in equal proportions the amount of the ~~assessment~~ assessments set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ss. 149.142 (1) (b) and 149.143 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165 (2) and (3), deductible reductions under s. 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5) (e). The ~~department~~ board shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

SECTION 56. 149.145 of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

149.145 Program budget. The ~~department, in consultation with the~~ board~~,~~ shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in ss. 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143,

149.144, and 149.146 for determining premium rates, insurer assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject to s. 149.142 (1) (b), from the program budget the ~~department~~ board shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The ~~department may not implement a program budget established under this section unless it is approved by the~~ board shall consult with the department as necessary in deriving the actual provider payment rate.

SECTION 57. 149.145 of the statutes, as affected by 2003 Wisconsin Act .... (this act), is amended to read:

149.145 Program budget. The board shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in ss. 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143, 149.144, and 149.146 for determining premium rates, insurer and manufacturer and labeler assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject to s. 149.142 (1) (b), from the program budget the board shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The board shall consult with the department as necessary in deriving the actual provider payment rate.

SECTION 58. 149.146 (1) (b) of the statutes is amended to read:

149.146 **(1)** (b) An eligible person under par. (a) may elect once each year, at the time and according to procedures established by the ~~department~~ board, among the coverages offered under this section and s. 149.14. If an eligible person elects new

coverage, any preexisting condition exclusion imposed under the new coverage is met to the extent that the eligible person has been previously and continuously covered under this chapter. No preexisting condition exclusion may be imposed on an eligible person who elects new coverage if the person was an eligible individual when first covered under this chapter and the person remained continuously covered under this chapter up to the time of electing the new coverage.

SECTION 59. 149.146 (2) (a) of the statutes, as affected by 2003 Wisconsin Act 33, is amended to read:

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

SECTION 60. 149.146 (2) (am) 4. of the statutes is amended to read:

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

SECTION 61. 149.146 (2) (am) 5. of the statutes is amended to read:

149.146 **(2)** (am) 5. Subject to s. 149.14 (8) (b), the ~~department~~ board may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and copayment and coinsurance out−of−pocket limits over which the plan will pay ~~100%~~ 100 percent of covered costs for prescription drugs. ~~Any copayment amount, coinsurance rate, or out−of−pocket~~

~~limit established under this subdivision is subject to the approval of the board.~~ Copayments and coinsurance paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

SECTION 62. 149.146 (2) (b) (intro.) of the statutes is amended to read:

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

SECTION 63. 149.146 (2) (b) 1. of the statutes is amended to read:

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

SECTION 64. 149.146 (2) (b) 2. of the statutes is amended to read:

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

SECTION 65. 149.15 (1) of the statutes is amended to read:

149.15 **(1)** The plan shall ~~have~~ operate under the direction of a board of governors consisting of representatives of 2 participating insurers that are nonprofit corporations, representatives of 2 other participating insurers, ~~3~~ 4 health care ~~provider~~ industry representatives, including one representative of ~~the State~~ Wisconsin Medical Society ~~of Wisconsin~~, one representative of ~~the~~ Wisconsin Health and Hospital Association, one representative of Pharmaceutical Research and

Manufacturers of America, and one representative of an integrated multidisciplinary health system, and 4 public members, including one representative of small businesses in the state, appointed by the secretary for staggered 3−year terms. In addition, the commissioner, or a designated representative from the office of the commissioner, and the secretary, or a designated representative from the department, shall be members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital, or an insurer. At least one of the public members shall be an individual who has coverage under the plan. The ~~secretary or the secretary's representative shall be~~ board annually shall select the chairperson of the board. Board members, except the commissioner or the commissioner's representative and the secretary or the secretary's representative, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

SECTION 66. 149.15 (3) (b) of the statutes is created to read:

149.15 **(3)** (b) Establish by rule the plan design, including covered benefits and exclusions. At least every 3 years, the board shall conduct a survey of health care plans available in the private market and make any adjustments to the plan that the board determines are advisable on the basis of the survey. Using the procedure under s. 227.24, the board may promulgate rules under this paragraph for the period before the effective date of any permanent rules promulgated under this paragraph, but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the board is not required to make a finding of emergency.

SECTION 67. 149.15 (3) (c) of the statutes is repealed.

SECTION 68. 149.15 (3) (e) of the statutes is created to read:

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

SECTION 69. 149.15 (3) (f) of the statutes is repealed.

SECTION 70. 149.15 (4) (c) of the statutes is created to read:

149.15 **(4)** (c) Contract with persons to provide professional services to the board and the plan.

SECTION 71. 149.15 (4) (d) of the statutes is created to read:

149.15 **(4)** (d) Notwithstanding ss. 625.11 (4) and 628.34 (3) (a) and any requirements in this chapter related to setting premium rates or amounts, establish for eligible persons with household incomes that exceed $100,000 a separate schedule of premium rates that are higher than the rates set for other eligible persons. Premium rates established under this paragraph may not exceed 200 percent of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and cost−sharing provisions that are provided under the plan. The board shall use excess premiums collected under a schedule established under this paragraph to reduce premiums for eligible persons with low household incomes, as determined by the board. Household income under this paragraph shall be determined in the same manner as household income is determined under s. 149.165 (2) and (3).

SECTION 72. 149.15 (5) of the statutes is repealed.

SECTION 73. 149.16 of the statutes, as affected by 2003 Wisconsin Act 33, is repealed.

SECTION 74. 149.165 (1) of the statutes is amended to read:

149.165 **(1)** Except as provided in s. 149.146 (2) (a), the ~~department~~ board shall reduce the premiums established ~~under s. 149.11~~ in conformity with ss. 149.14 (5m),

149.143, and 149.17 for the eligible persons and in the manner set forth in subs. (2) and (3).

SECTION 75. 149.165 (2) of the statutes is amended to read:

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

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

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

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

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

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

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

SECTION 76. 149.165 (3) (a) of the statutes is amended to read:

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

SECTION 77. 149.165 (3) (b) (intro.) of the statutes is amended to read:

149.165 **(3)** (b) (intro.) In determining household income under sub. (2), the ~~department~~ board shall consider information submitted by an eligible person on a completed federal profit or loss from farming form, schedule F, if all of the following apply:

SECTION 78. 149.165 (3r) of the statutes is created to read:

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

SECTION 79. 149.17 (4) of the statutes is amended to read:

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

SECTION 80. 149.175 of the statutes is amended to read:

149.175 Waiver or exemption from provisions prohibited. Except as provided in ~~s.~~ ss. 149.13 (1) and 149.132 (1) (b), the department or the board may not waive~~, or authorize the board to waive,~~ any of the requirements of this chapter or exempt~~, or authorize the board to exempt,~~ an individual or a class of individuals from any of the requirements of this chapter.

SECTION 81. 149.20 of the statutes is amended to read:

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

SECTION 82. 149.25 (2) (a) of the statutes is amended to read:

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

SECTION 83. 149.25 (4) of the statutes is amended to read:

149.25 **(4)** EVALUATION STUDY. The department, in consultation with the board, shall conduct a study that evaluates the pilot program in terms of health care

outcomes and cost avoidance. In the study, the department shall measure and compare, for pilot program participants and similarly situated eligible persons not participating in the pilot program, plan costs and utilization of services, including inpatient hospital days, rates of hospital readmission within 30 days for the same diagnosis, and prescription drug utilization. The department shall submit a report on the results of the study, including the department's conclusions and recommendations, to the legislature under s. 13.172 (2) and to the governor.

SECTION 84. 450.10 (2m) of the statutes is created to read:

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

SECTION 85. Nonstatutory provisions.

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

(2) SELECTION OF PLAN ADMINISTRATOR. The board of governors of the Health Insurance Risk−Sharing Plan shall, no later than July 1, 2004, issue a request−for−proposals under section 149.15 (3) (e) of the statutes, as created by this act, for administration of the Health Insurance Risk−Sharing Plan.

(3) DRUG MANUFACTURER AND LABELER ASSESSMENTS. Notwithstanding section 149.132 of the statutes, as created by this act, the first assessment under section 149.132 of the statutes, as created by this act, that is payable by prescription drug manufacturers and labelers shall be calculated on prescription drug claims paid by the Health Insurance Risk−Sharing Plan from July 1, 2004, to December 31, 2004, rather than on total prescription drug claims paid in 2004.

SECTION 86. Initial applicability.

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

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

(3) DRUG MANUFACTURER AND LABELER ASSESSMENTS. The treatment of sections 25.55 (3), 149.10 (5f) and (5r), 149.132, 149.143 (1) (bm) 1., 1m., 2., and 2m. (intro.), (2) (a) 3. and 4., (3) (a) (by SECTION 49), and (5) (a) (by SECTION 53), 149.145 (by SECTION 57), and 450.10 (2m) of the statutes first applies to drug manufacturer and labeler assessments that are payable with respect to claims paid on July 1, 2004.

SECTION 87. Effective dates. This act takes effect on the day after publication, except as follows:

(1) ELIGIBILITY. The treatment of section 149.12 (1) (a), (am), (b), and (c) of the statutes and SECTION 86 (2) of this act take effect on the first day of the 4th month beginning after publication.

(2) DRUG MANUFACTURER AND LABELER ASSESSMENTS. The treatment of sections 25.55 (3), 149.10 (5f) and (5r), 149.132, 149.143 (1) (bm) 1., 1m., 2., and 2m. (intro.), (2) (a) 3. and 4., (3) (a) (by SECTION 49), and (5) (a) (by SECTION 53), 149.145 (by SECTION 57), and 450.10 (2m) of the statutes takes effect on July 1, 2004.

(END)