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2005 ASSEMBLY BILL 1140

March 21, 2006 − Introduced by Representatives GIELOW and RICHARDS. Referred to Committee on Insurance. Referred to Joint Survey Committee on Tax Exemptions.

AN ACT ***to amend*** 40.51 (1), 111.70 (1) (dm), 632.755 (1g) (a) and 632.755 (1g) (b); and ***to create*** 13.94 (1s) (c) 5., 20.855 (8m), 25.17 (1) (gd), 25.775, 71.83 (1) (ce), subchapter XVI of chapter 71 [precedes 71.98], 111.91 (2) (pm), 149.12 (2) (g) 7. and chapter 260 of the statutes; **relating to:** creating the Private Health Insurance Purchasing Corporation of Wisconsin, establishing a health insurance purchasing arrangement through the use of private accounts for all state residents, adopting federal law as it relates to health savings accounts for state income and franchise tax purposes, making appropriations, and providing a penalty.

Analysis by the Legislative Reference Bureau

Health insurance purchasing arrangement; corporation

This bill establishes a private health insurance purchasing arrangement (PHIPA) to provide health insurance coverage for state residents, and creates a private, nonstock corporation, called the Private Health Insurance Purchasing Corporation of Wisconsin (corporation), to facilitate and administer PHIPA. The eight members of the corporation's board of directors are designated by the governor and various business organizations and labor unions. The corporation's meetings

must be open to the public, and it must keep its records open to inspection by the governor, the secretary of administration, any committee of the legislature, the Legislative Fiscal Bureau, and the Legislative Audit Bureau, which must conduct both a financial audit of the corporation and a performance evaluation audit of PHIPA at least once every two years. The corporation must keep its hiring practices and its procedures for soliciting bids or proposals in writing and open to public inspection, as well as all of its requests for bids or proposals and its analyses of, and final decisions on, bids and proposals received. The corporation must annually report to the governor and the legislature on its activities.

Eligibility; establishing accounts

Every eligible resident is eligible for PHIPA. An eligible resident is defined in the bill as an individual who is under 65 years of age; who has been domiciled in the state for at least six months or, if under six months old, whose parent or guardian has been domiciled in the state for at least six months; who maintains a substantial presence in the state; and who is not an inmate of a penal facility, not a resident of an institution for the mentally ill or developmentally disabled, not eligible for health care coverage from the federal government, and not eligible for Medical Assistance or Badger Care unless a waiver from the federal secretary of health and human services is granted that allows individuals who are eligible for Medical Assistance or Badger Care to be covered under PHIPA.

Beginning in 2008, the corporation must establish for every eligible resident, except for one who objects for religious reasons, a private health insurance purchasing account (account). The account of every eligible resident who is at least 18 years of age will include a health savings account (HSA).

Insurers; health care plans

The corporation must solicit bids from, and contract with, insurers to offer health care plans under PHIPA. There must be at least two health care plans offered by at least two insurers in each county of the state. The corporation must rank, on a countywide basis, each of the health care plans offered, assign each plan to one of three tiers, and determine the premium for each. Plans that the corporation determines provide high quality care at a low risk−adjusted cost will be assigned to Tier 1; plans that the corporation determines provide care at a higher risk−adjusted cost will be assigned to Tier 2; and plans that the corporation determines provide care at the highest risk−adjusted cost will be assigned to Tier 3. Every year there will be an open enrollment period during which each eligible resident may select a health care plan from among those offered. An eligible resident who does not select a plan will be randomly assigned to a Tier 1 plan.

Funding and uses of accounts

Although the bill does not provide a funding source or mechanism, the accounts and HSAs are to be funded beginning in 2009, which is also when coverage under PHIPA begins. The amount that is to be credited to each eligible resident's account is the full premium amount for coverage under a Tier 1 plan in the county in which the eligible resident resides, actuarially adjusted for the eligible resident's age, sex, and other appropriate risk factors. The corporation pays this amount to the health care plan selected by the eligible resident. Only if an eligible resident has selected

a Tier 2 or Tier 3 plan must he or she pay any additional, out−of−pocket amount for the premium. The bill provides that the amount credited to an eligible resident's HSA will be $500 in 2009, and adjusted to reflect changes in the U.S. consumer price index for years after that. The amount credited to an HSA, however, may be increased or decreased for various reasons, such as whether the eligible resident follows a healthy lifestyle protocol and whether the corporation estimates that revenues will exceed expenses or expenses will exceed revenues in a given year. Federal law requires that amounts credited to an HSA must be used to pay for medical care.

Benefits; cost−sharing; preexisting condition exclusion

Every health care plan offered will provide the same benefits and, except for premiums, will require the same cost−sharing. Benefits under PHIPA include medical and hospital care coverage and related health care services, prescription drug coverage, and limited dental care. Cost−sharing, including deductibles, coinsurance, and copayments, will not apply to certain types of care, including emergency care, prenatal care, medically indicated immunizations for children, and other specified types of preventive care. However, benefits may be reduced, under a procedure outlined in the bill, if the corporation determines that expenses will exceed revenues for a given year or years.

Except for those services to which cost−sharing does not apply, each eligible resident who is at least 18 years old on January 1 must pay a deductible of $1,200 in that year, and each eligible resident who is less than 18 years old on January 1 must pay a deductible of $100 in that year. After the deductible has been satisfied, an eligible resident must pay coinsurance of between 10 and 20 percent, as determined by the corporation, for prescription drugs and covered services, except for those services to which cost−sharing does not apply. Prescription drugs are subject to additional coinsurance or copayments, as determined by the corporation. The additional coinsurance or copayments must be higher for prescription drugs that are not on a preferred list determined by the corporation.

Notwithstanding the required deductible, coinsurance, and copayment amounts, an eligible resident who is at least 18 years old on January 1 may not be required to pay more than $2,000 per year in total cost−sharing; an eligible resident who is less than 18 years old on January 1 may not be required to pay more than $500 per year in total cost−sharing; and a family of two or more eligible residents may not be required to pay more than $3,000 per year in total cost−sharing. In addition, the corporation must reduce one or more of the cost−sharing amounts for low−income eligible residents, and the deductible and maximum cost−sharing amounts are to be adjusted annually to reflect changes in the U.S. consumer price index.

There is a coverage exclusion for any preexisting condition of an eligible resident who, at any time during the 18 months before becoming an eligible resident, resided outside of Wisconsin and did not have health insurance coverage substantially similar to the coverage under PHIPA. However, the preexisting condition exclusion may not extend beyond the date on which the eligible resident has been continuously covered under PHIPA for a total of 18 months.

Health care advisory committee

The corporation is required to establish a health care advisory committee to advise it on specified health−related issues. The corporation must consult with the health care advisory committee and other experts on various health−related issues, such as creating incentives for eligible residents to adopt healthier lifestyles and increasing transparency of health care cost and quality information, and must adopt policies that further these goals.

Waiver of federal requirements; proposed legislation

Under the bill, the corporation and the Department of Health and Family Services (DHFS) must develop a plan for providing coverage under PHIPA for individuals who would be eligible residents except that they are eligible for Badger Care or for Medical Assistance under what DHFS determines is the low−income families category. DHFS must submit the plan to the legislature, along with its recommendations on the desirability of requesting waivers that would allow implementation of the plan and the use of federal financial participation to fund health care coverage for those individuals under PHIPA. If DHFS requests waivers upon the authorization of the legislature, and if the waivers are granted, DHFS must submit proposed legislation implementing the provisions approved under the waivers. In addition, to facilitate the provision of coverage under PHIPA for individuals who are eligible for Badger Care or for Medical Assistance under what DHFS determines is the low−income families category, DHFS and the Legislative Fiscal Bureau must submit proposed legislation that separates the Medical Assistance provisions of the statutes, including related appropriations, into two eligibility categories, one for low−income families and one for elderly and disabled persons.

Adoption of federal law for health savings accounts

The bill adopts, for state income and franchise tax purposes, section 1201 of Public Law 108−173 as it relates to claiming a deduction for an amount that a person pays into a health savings account.

This bill will be referred to the Joint Survey Committee on Tax Exemptions for a detailed analysis, which will be printed as an appendix to this bill.

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

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

SECTION 1. 13.94 (1s) (c) 5. of the statutes is created to read:

13.94 **(1s)** (c) 5. The Private Health Insurance Purchasing Corporation of Wisconsin for the cost of the audits under s. 260.05 (4).

SECTION 2. 20.855 (8m) of the statutes is created to read:

20.855 **(8m)** PRIVATE HEALTH INSURANCE PURCHASING CORPORATION OF WISCONSIN. (r) *Health insurance purchasing accounts and administration.* After deducting the amounts appropriated for the state's share of benefits and administrative costs under the Medical Assistance program that are attributable to the low−income families category, as determined under 2005 Wisconsin Act .... (this act), section 14 (1) (b) and the amounts appropriated for the state's share of benefits and administrative costs under the Badger Care health care program under s. 49.665, the balance of the moneys in the health insurance purchasing trust fund to be paid to the Private Health Insurance Purchasing Corporation of Wisconsin for establishing, funding, managing, and assisting individuals with the use of, the health insurance purchasing accounts established under ch. 260.

SECTION 3. 25.17 (1) (gd) of the statutes is created to read:

25.17 **(1)** (gd) Health insurance purchasing trust fund (s. 25.775);

SECTION 4. 25.775 of the statutes is created to read:

25.775 Health insurance purchasing trust fund. There is established a separate, nonlapsible trust fund designated as the health insurance purchasing trust fund, consisting of all moneys appropriated or transferred to or deposited in the fund.

SECTION 5. 40.51 (1) of the statutes is amended to read:

40.51 **(1)** The procedures and provisions pertaining to enrollment, premium transmitted and coverage of eligible employees for health care benefits shall be established by contract or rule except as otherwise specifically provided by this chapter. Health care benefits provided under this subchapter shall be in addition to health care benefits provided eligible employees under ch. 260.

SECTION 6. 71.83 (1) (ce) of the statutes is created to read:

71.83 **(1)** (ce) *Health savings accounts.* Any person who is liable for a penalty for federal income tax purposes under section 223 (f) (4) of the Internal Revenue Code is liable for a penalty equal to 33 percent of that penalty. The department of revenue shall assess, levy, and collect the penalty under this paragraph as it assesses, levies, and collects taxes under this chapter.

SECTION 7. Subchapter XVI of chapter 71 [precedes 71.98] of the statutes is created to read:

CHAPTER 71

SUBCHAPTER XVI

INTERNAL REVENUE CODE UPDATE

71.98 Internal Revenue Code update. The following federal laws, to the extent that they apply to the Internal Revenue Code, apply to this chapter:

(1) HEALTH SAVINGS ACCOUNTS. Section 1201 of P.L. 108−173, relating to health savings accounts.

SECTION 8. 111.70 (1) (dm) of the statutes is amended to read:

111.70 **(1)** (dm) "Economic issue" means salaries, overtime pay, sick leave, payments in lieu of sick leave usage, vacations, clothing allowances in excess of the actual cost of clothing, length−of−service credit, continuing education credit, shift premium pay, longevity pay, extra duty pay, performance bonuses, health insurance coverage of benefits not provided under ch. 260, life insurance, dental insurance, disability insurance, vision insurance, long−term care insurance, worker's compensation and unemployment insurance, social security benefits, vacation pay, holiday pay, lead worker pay, temporary assignment pay, retirement contributions, supplemental retirement benefits, severance or other separation pay, hazardous

duty pay, certification or license payment, limitations on layoffs that create a new or increased financial liability on the employer and contracting or subcontracting of work that would otherwise be performed by municipal employees in the collective bargaining unit with which there is a labor dispute.

SECTION 9. 111.91 (2) (pm) of the statutes is created to read:

111.91 **(2)** (pm) Health care coverage of employees under ch. 260.

SECTION 10. 149.12 (2) (g) 7. of the statutes is created to read:

149.12 **(2)** (g) 7. Health care coverage under the health insurance purchasing arrangement under ch. 260.

SECTION 11. Chapter 260 of the statutes is created to read:

CHAPTER 260

HEALTH INSURANCE PURCHASING ACCOUNTS

260.01 Definitions. In this chapter:

(1) "Board" means the board of directors of the corporation.

(2) "Corporation" means the Private Health Insurance Purchasing Corporation of Wisconsin.

(3) (a) "Eligible resident" means an individual who satisfies all of the following criteria:

1. The individual has been domiciled, as defined by the corporation, in this state for at least 6 months, except that, if a child is under 6 months of age, the child is an "eligible resident" if the child lives in this state and at least one of the child's parents or the child's guardian has been domiciled, as defined by the corporation, in this state for at least 6 months.

2. The individual maintains a substantial presence in this state, as defined by the corporation. In defining what constitutes a substantial presence in this state, the

corporation shall consider such factors as the amount of time per year that an individual is actually present in the state and the amount of taxes that an individual pays in this state, except that if the individual attends school outside of this state and is under 23 years of age, the factors shall include the amount of time that the individual's parent or guardian is actually present in the state and the amount of taxes that the individual's parent or guardian pays in this state, and if the individual is in active service with the U.S. armed forces outside of this state, the factors shall include the amount of time that the individual's parent, guardian, or spouse is actually present in the state and the amount of taxes that the individual's parent, guardian, or spouse pays in this state.

3. The individual is under 65 years of age.

4. The individual is not eligible for health care coverage from the federal government, is not an inmate of a penal facility, as defined in s. 19.32 (1e), and is not placed or confined in, or committed to, an institution for the mentally ill or developmentally disabled.

5. Unless a waiver is requested under s. 260.60 and granted and in effect, the individual is not eligible for medical assistance under subch. IV of ch. 49 or for health care coverage under the Badger Care health care program under s. 49.665.

(b) Notwithstanding par. (a), an individual who satisfies par. (a) 1. to 5. and who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2009, is not an "eligible individual" until the day on which the collective bargaining agreement expires.

260.05 Private Health Insurance Purchasing Corporation of Wisconsin. (1) INCORPORATION. The secretary of administration shall do all of the following:

(a) Draft and file articles of incorporation for a nonstock corporation under ch. 181 and take all actions necessary to exempt the corporation from federal taxation under section 501 (c) (3) of the Internal Revenue Code.

(b) Provide in the articles of incorporation filed under par. (a) all of the following:

1. That the name of the corporation is the "Private Health Insurance Purchasing Corporation of Wisconsin."

2. That the board shall consist of 8 directors who, except for the initial directors, shall be designated or appointed as follows:

a. One designated by Wisconsin Manufacturers and Commerce.

b. One designated by the Wisconsin State American Federation of Labor and Congress of Industrial Organizations.

c. One designated by the Metropolitan Milwaukee Association of Commerce.

d. One designated by the Wisconsin office of the National Federation of Independent Business.

e. One designated by the Wisconsin Farm Bureau Federation.

f. One designated by the SEIU Wisconsin State Council.

g. Two designated by the governor to represent consumers.

3. That the term of a director shall be 4 years, except that the term of an initial director shall be one year.

4. The names and addresses of the initial directors.

5. That 7 votes shall be necessary for adoption of any decision of the board, except for those designated categories of decisions, if any, that the board agrees to adopt by a simple majority of the votes.

(c) In consultation with the persons charged with designating the directors under par. (b) 2. a. to g., designate the initial directors.

(d) Draft bylaws for adoption by the board.

(2) DUTIES. As a condition for the release of funds under s. 20.855 (8m) (r), the corporation shall do all of the following:

(a) Establish, fund, and manage health insurance purchasing accounts in the manner provided in this chapter; assist eligible residents in using their accounts to purchase health care coverage; and perform all other functions required of the corporation under this chapter.

(b) Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the corporation.

(c) Keep its records open at all times to inspection and examination by the governor, the secretary of administration, any committee of either or both houses of the legislature, the legislative fiscal bureau, and the legislative audit bureau.

(d) Keep its meetings open to the public to the extent required of governmental bodies under subch. V of ch. 19.

(e) Cooperate with the legislative audit bureau in the performance of the audits under sub. (4).

(f) Submit on each October 1 an annual report to the legislature under s. 13.172 (2) and to the governor regarding its activities and including any recommendations of the health care advisory committee under s. 260.40 (1) (d).

(3) CONTRACTS AND HIRING. (a) The corporation may contract with other organizations, entities, or individuals for the performance of any of its functions. With respect to contracts under this subsection, the corporation shall do all of the following:

1. Use generally accepted procedures, which shall be in writing and open to public inspection, for soliciting bids or proposals and for awarding contracts to the lowest−bidding, qualified person or to the most qualified person submitting a proposal.

2. Make open to public inspection all of its requests for bids or proposals, all of its analyses of bids or proposals received, and all of its final decisions on bids or proposals received.

(b) The corporation shall use generally accepted hiring practices, which shall be in writing and open to public inspection, for hiring any staff.

(4) AUDITS. At least once every 2 years, the legislative audit bureau shall conduct a financial audit of the corporation and a performance evaluation audit of the health insurance purchasing arrangement under this chapter that includes an audit of the corporation's policies and management practices. The legislative audit bureau shall distribute a copy of each audit report under this subsection to the legislature under s. 13.172 (2) and to the governor. The corporation shall reimburse the legislative audit bureau for the cost of the audits and reports required under this subsection.

260.10 Health insurance purchasing accounts. (1) ESTABLISHMENT AND FUNDING. (a) Beginning in January 2008, the corporation shall establish a private health insurance purchasing account for each eligible resident, except for an eligible resident who notifies the corporation that, for religious reasons, he or she does not wish to have an account. Beginning in 2009, the corporation annually shall credit to each account a dollar amount that is the full premium, as determined by the corporation under s. 260.15 (2) (b), of any of the Tier 1 health care plans offered in the county in which the eligible resident resides and that has been actuarially

adjusted for the eligible resident based on age, sex, and other appropriate risk factors determined by the board. Subject to sub. (2) and s. 260.20 (3), the corporation shall pay the amount credited under this paragraph to the health care plan selected by the eligible resident, or to which the eligible resident has been assigned, under s. 260.15 (3).

(b) 1. The health insurance purchasing account of an eligible resident who is at least 18 years of age shall also include a health savings account, as described in 26 USC 223. For an eligible resident who is under 18 years of age when his or her health insurance purchasing account is established, his or her health insurance purchasing account shall include a health savings account beginning in the year in which the eligible resident is 18 years of age on January 1.

2. Beginning in 2009, the corporation annually shall deposit an amount into each health savings account. Subject to s. 260.20 (5), the amount deposited in 2009 shall be $500 and the amount deposited in each year thereafter shall be adjusted to reflect the annual percentage change in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, for the 12−month period ending on December 31 of the preceding year.

3. If the corporation estimates that revenues will exceed costs in a year, the corporation may deposit into each health savings account an amount in addition to the amount deposited under subd. 2.

4. In addition to amounts deposited under subds. 2. and 3., the corporation may deposit into the health savings account of an eligible resident who successfully follows a healthy lifestyle protocol certified by the corporation under s. 260.40 (2) (a), an amount determined by the corporation to be equal to the average reduction in health care costs per eligible resident who adopts a healthy lifestyle protocol.

5. Notwithstanding subds. 2., 3., and 4., the total amount deposited in an eligible resident's health savings account may not exceed the maximum amount allowed under federal law.

(2) ADDITIONAL PAYMENT FOR DISPROPORTIONATE RISK. The corporation may retain a percentage of the amounts credited under sub. (1) (a) to pay to health care plans that have incurred disproportionate risk not fully compensated for by the actuarial adjustment in the amount credited to each account under sub. (1) (a). Any payment to a health care plan under this subsection shall reflect the disproportionate risk incurred by the health care plan.

260.15 Health care plans. (1) PARTICIPATION OF INSURERS. (a) Subject to par. (c), the corporation shall solicit bids from, and enter into contracts with, insurers for offering coverage to eligible residents. Any insurer that is authorized to do business in this state in one or more lines of insurance that includes health insurance is eligible to submit a bid.

(b) In determining which insurers qualify to offer coverage, the corporation shall use financial, coverage, and disclosure standards that are comparable to those that the department of employee trust funds has used in qualifying insurers for offering coverage under the state employee health plan under s. 40.51 (6).

(c) The corporation shall ensure that in each county at least 2 health care plans are offered by at least 2 different insurers.

(2) TIER ASSIGNMENT AND PREMIUM DETERMINATION. (a) The corporation shall rank the health care plans offered in each county and assign each health care plan to one of 3 tiers, on a countywide basis, based on the health care plan's risk−adjusted cost and quality. The corporation shall assign to "Tier 1" health care plans that it determines provide high quality care at a low risk−adjusted cost, assign to "Tier 2"

health care plans that it determines provide care at a higher risk−adjusted cost, and assign to "Tier 3" health care plans that it determines provide care at the highest risk−adjusted cost.

(b) The corporation shall determine the monthly premium amount for each health care plan, including the out−of−pocket monthly premium amounts that eligible residents must pay to enroll in Tier 2 health care plans and Tier 3 health care plans. The out−of−pocket monthly premium amounts shall be based on the actual differences in risk−adjusted cost between Tier 1 and Tier 2 health care plans, and between Tier 1 and Tier 3 health care plans.

(3) PLAN SELECTION. Beginning in 2008, the corporation shall offer an annual open enrollment period during which each eligible resident may select a health care plan from among those offered. Coverage under the health care plan that an eligible resident selects during an annual open enrollment period shall be effective on the following January 1. An eligible resident who does not select a health care plan will be randomly assigned to a Tier 1 health care plan. An eligible resident who selects a Tier 2 or Tier 3 health care plan but who fails, as defined by the corporation, to pay the out−of−pocket monthly premium amount will be randomly assigned to a Tier 1 health care plan.

260.20 Benefits. (1) GENERALLY. Coverage under this chapter shall begin on January 1, 2009, and shall include medical and hospital care coverage and related health care services as determined by the corporation, prescription drug coverage, and limited dental care coverage, as provided in sub. (4).

(2) BENEFITS WITHOUT CERTAIN COST SHARING. Deductibles, coinsurance, and copayments shall not apply to coverage of any of the following health care services, as defined by the corporation:

(a) Emergency care.

(b) Prenatal care for pregnant women.

(c) Well−baby care.

(d) Annual medical examinations for children up to 18 years of age.

(e) Medically indicated immunizations for children up to 18 years of age.

(f) Annual gynecological examinations for older girls and women.

(g) Medically indicated Papanicolaou tests and mammograms.

(h) Annual medical examinations for older men.

(i) Medically indicated colonoscopies.

(j) The limited dental care specified in sub. (4).

(k) Other preventive services or procedures, as determined by the corporation, for which there is scientific evidence that exemption from cost sharing is likely to reduce health care costs or avoid health risks.

(3) PHARMACY BENEFIT. (a) Except as provided in par. (b), the corporation shall assume the risk for, and pay for, prescription drugs provided to eligible residents. For this purpose, the corporation shall retain the portion of the amount credited under s. 260.10 (1) (a) that is actuarially allocated for prescription drug coverage.

(b) If the corporation determines that the method of providing prescription drug coverage under par. (a) is not cost−effective, the corporation may require the health care plans to provide prescription drug coverage to eligible residents and shall pay the portion of the amount credited under s. 260.10 (1) (a) that is actuarially allocated for prescription drug coverage to the eligible residents' health care plans.

(4) DENTAL BENEFIT. Every health care plan shall provide coverage of dental examinations and the application of varnishes and sealants, as determined by the

corporation, for eligible residents who are at least 2 years of age but not more than 16 years of age.

(5) BENEFIT AND HEALTH SAVINGS ACCOUNT DEPOSIT REDUCTIONS. (a) If the corporation determines, based on information and recommendations received from its actuaries, that the cash balance in the health insurance purchasing trust fund is likely to be insufficient for providing the health care benefits under subs. (1) to (4), the corporation shall inform the governor and the legislature of all of the following:

1. That expenses will exceed revenues for one or more specified years.

2. What increase in revenues would be required to maintain the current health savings account and benefit levels and bring revenues and expenses into balance for the year or years specified in subd. 1.

3. Alternative reductions in the amount deposited into health savings accounts under s. 260.10 (1) (b) 2. or in the benefits under this section that would be appropriate to bring revenues and expenses into balance for the year or years specified in subd. 1.

4. The revenue increase, health savings account deposit reduction, or benefit reductions, or the combination of increase and reductions, that the corporation recommends to bring revenues and expenses into balance for the year or years specified in subd. 1.

5. The health savings account deposit reduction or benefit reductions that the corporation prefers to bring revenues and expenses into balance for the year or years specified in subd. 1. if legislation that increases revenues, reduces the health savings account deposit under s. 260.10 (1) (b) 2., or reduces benefits provided under this section is not enacted before the beginning of the first year specified in subd. 1.

(b) If legislation to bring revenues and expenses into balance for the year or years specified in par. (a) 1. is not enacted before the beginning of the first year specified, the corporation shall implement the health savings account deposit reduction or benefit reductions specified in par. (a) 5.

260.25 Cost sharing. (1) PREMIUMS. (a) An eligible resident who selects or is assigned to coverage under a Tier 1 health care plan shall pay no premium in addition to the amount paid by the corporation under s. 260.10 (1) (a) to the eligible resident's health care plan.

(b) An eligible resident who selects coverage under a Tier 2 or Tier 3 health care plan shall be required to pay to the selected Tier 2 or Tier 3 health care plan, as a condition of enrollment, the out−of−pocket monthly premium determined by the corporation under s. 260.15 (2) (b).

(2) DEDUCTIBLES. Except as provided in s. 260.20 (2) and subject to sub. (4), in a year, an eligible resident shall pay the following annual deductible amount:

(a) For an eligible resident who is 18 years of age or older on January 1 of that year, $1,200.

(b) For an eligible resident who is under 18 years of age on January 1 of that year, $100.

(3) COINSURANCE AND COPAYMENTS. Except as provided in s. 260.20 (2) and subject to sub. (4), in a year, after the deductible under sub. (2) has been satisfied, an eligible resident shall pay all of the following:

(a) Coinsurance that is equal to at least 10 percent but not more than 20 percent of medical, hospital, related health care services, and prescription drug costs, as determined by the corporation.

(b) For each prescription of a brand−name drug that is on the preferred list determined by the corporation under s. 260.20 (3) (a) or by the eligible resident's health care plan under s. 260.20 (3) (b), in addition to the coinsurance required under par. (a), either coinsurance of at least 10 percent but not more than 20 percent or a copayment, as determined by the corporation.

(c) For each prescription of a brand−name drug that is not on the preferred list determined by the corporation under s. 260.20 (3) (a) or by the eligible resident's health care plan under s. 260.20 (3) (b), in addition to the coinsurance required under par. (a), either coinsurance of at least 20 percent but not more than 40 percent or a copayment, as determined by the corporation.

(4) MAXIMUM AMOUNTS. (a) Subject to par. (c), an eligible resident under sub. (2) (a) may not be required to pay more than $2,000 per year in total cost sharing under subs. (2) and (3).

(b) Subject to par. (c), an eligible resident under sub. (2) (b) may not be required to pay more than $500 per year in total cost sharing under subs. (2) and (3).

(c) A family consisting of 2 or more eligible residents may not be required to pay more than $3,000 per year in total cost sharing under subs. (2) and (3).

(5) ADJUSTMENTS. (a) Notwithstanding subs. (2) to (4), the corporation shall reduce the deductible, coinsurance, copayment, or maximum cost−sharing amounts, or any combination of those amounts, for low−income eligible residents, as determined by the corporation, to ensure that the cost sharing required does not deter low−income eligible residents from seeking and using appropriate health care services.

(b) Notwithstanding subs. (2) to (4), beginning in 2010, the corporation annually shall adjust the deductible and maximum cost−sharing amounts to reflect

the annual percentage change in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, for the 12−month period ending on December 31 of the preceding year.

260.30 Preexisting condition exclusion. (1) TO WHOM APPLICABLE. Subject to sub. (2), a health care plan may not provide coverage for any preexisting condition, as defined by the corporation, of an eligible resident who, at any time during the 18−month period before becoming an eligible resident, resided outside of Wisconsin and did not have health insurance coverage that was substantially similar to the coverage provided under this chapter, as determined by the corporation.

(2) LENGTH OF EXCLUSION. A preexisting condition exclusion under sub. (1) may not extend beyond the date on which the eligible resident has been continuously covered under this chapter for a total of 18 months.

260.40 Health care advisory committee; health care policies. (1) ESTABLISHMENT OF COMMITTEE. (a) The corporation shall establish a health care advisory committee to advise it on all matters related to promoting healthier lifestyles; promoting health care quality; increasing the transparency of health care cost and quality information; preventive care; disease management; the appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms; confidentiality of medical information; the appropriate use of technology; benefit design; the availability of physicians, hospitals, and other providers; and reducing health care costs.

(b) The committee shall consist of the following:

1. Three members designated by the Wisconsin Medical Society.

2. Three members designated by the Wisconsin Hospital Association.

3. One member designated by the dean of the University of Wisconsin School of Medicine and Public Health.

4. One member designated by the president of the Medical College of Wisconsin.

5. One member designated by the Wisconsin Nurses Association.

6. One member designated by the Wisconsin Federation of Nurses and Health Professionals.

7. One member designated by the Wisconsin Chiropractic Association.

8. One member designated by the Wisconsin Dental Association.

(c) The committee members shall elect a chairperson from among the members. The chairperson, or his or her designee, shall attend every meeting of the board to communicate to the corporation the advice and recommendations of the committee. The chairperson, or his or her designee, shall communicate to the committee any questions on which the corporation is seeking the committee's advice or recommendations. The corporation shall vote on each recommendation submitted to it by the committee as to whether the recommendation should be implemented.

(d) Annually, on or before September 1, the committee shall submit to the corporation a summary of all of its recommendations during the previous 12 months for improving the health insurance purchasing arrangement under this chapter. The corporation shall include those recommendations and the votes taken by the corporation on them in its annual report under s. 260.05 (2) (f).

(2) ADOPTION OF HEALTH CARE POLICIES. The corporation shall do all of the following:

(a) In consultation with the health care advisory committee and experts on creating effective incentives for individuals and employers relating to healthier

lifestyles, adopt evidence−based policies that create incentives for eligible residents to adopt healthier lifestyles and for employers to institute work−based programs that have been shown to improve the health status of employees and their families.

(b) In consultation with the health care advisory committee and experts on increasing the transparency of health care cost and quality information, and in collaboration with the health care advisory committee and health care plans and health care providers, adopt policies that provide eligible residents with current, comprehensive, easily accessible, and easily understandable information about the cost and quality of the care provided by Wisconsin health care providers and by any physicians, clinics, or hospitals outside of Wisconsin that are included in a network of a health care plan offered under the health insurance purchasing arrangement under this chapter.

(c) In consultation with the health care advisory committee, the Wisconsin Health Information Organization, the Wisconsin Collaborative for Health Care Quality, and other medical and nonmedical experts on health care quality, promote evidence−based improvements in the quality of health care delivery in Wisconsin.

260.60 Including certain residents who are eligible for Medical Assistance. (1) PLAN. The corporation and the department of health and family services shall jointly develop a plan for providing health care coverage under the health insurance purchasing arrangement established under this chapter to individuals who satisfy the criteria under s. 260.01 (3) (a) 1. to 4. and who are eligible for Medical Assistance under subch. IV of ch. 49 in the low−income families category, as determined under 2005 Wisconsin Act .... (this act), section 14 (1) (b), or for health care coverage under the Badger Care health care program under s. 49.665.

(2) WAIVER REQUEST. The department of health and family services shall, no later than July 1, 2010, submit to the legislature under s. 13.172 (2) the plan developed under sub. (1), together with its recommendations concerning the desirability of requesting waivers from the secretary of the federal department of health and human services for all of the following purposes:

(a) To implement the plan developed under sub. (1).

(b) To allow the use of federal financial participation to fund, to the maximum extent possible, health care coverage under the arrangement established under this chapter for individuals specified in sub. (1).

(3) PROPOSED LEGISLATION. If the legislature authorizes or requires the department of health and family services to request the waivers specified in sub. (2) and if the waivers are granted, the department of health and family services shall submit to the appropriate standing committees under s. 13.172 (3) proposed legislation that will implement the provisions approved under the waivers.

SECTION 12. 632.755 (1g) (a) of the statutes is amended to read:

632.755 **(1g)** (a) ~~A~~ Except as provided under ch. 260, a disability insurance policy may not exclude a person or a person's dependent from coverage because the person or the dependent is eligible for assistance under ch. 49 or because the dependent is eligible for early intervention services under s. 51.44.

SECTION 13. 632.755 (1g) (b) of the statutes is amended to read:

632.755 **(1g)** (b) ~~A~~ Except as provided under ch. 260, a disability insurance policy may not terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for assistance under ch. 49 or because the dependent is eligible for early intervention services under s. 51.44.

SECTION 14. Nonstatutory provisions.

(1) PROPOSED LEGISLATION ON ELIGIBILITY OF AND APPROPRIATIONS FOR MEDICAL ASSISTANCE AND BADGER CARE RECIPIENTS.

(a) *Definition.* In this subsection, "department" means the department of health and family services.

(b) *Eligibility categories for Medical Assistance.*

1. The department shall review the statutes and determine which statutory provisions specify eligibility criteria for Medical Assistance by each of the following categories of persons:

a. Low−income families.

b. Elderly or disabled persons.

2. No later than April 1, 2008, the department shall submit the findings of its review under subdivision 1. to the appropriate standing committees of the legislature in the manner provided under section 13.172 (3) of the statutes. If the department determines that one or more statutory provisions provide eligibility criteria that apply to both categories of persons under subdivision 1., along with its findings the department shall submit proposed legislation specifying eligibility criteria for Medical Assistance that clearly separates the 2 categories of persons under subdivision 1. so that any single statutory unit applies to only one of the 2 categories.

(c) *Appropriations for Medical Assistance and Badger Care.*

1. The department and the legislative fiscal bureau shall review the following Medical Assistance and Badger Care health care program appropriations to determine what amount of each of the total amounts appropriated under each of the appropriations is attributable to benefits provided to, or the administrative costs of

providing benefits to, Medical Assistance recipients in the category under paragraph (b) 1. a. or Badger Care health care program recipients:

a. Section 20.435 (2) (gk) of the statutes.

b. Section 20.435 (4) (a), (b), (bc), (bm), (bn), (gp), (iL), (im), (in), (kt), (L), (vt), (w), (wm), (wp), and (x) of the statutes.

c. Section 20.435 (6) (ga) and (k) of the statutes.

d. Section 20.435 (7) (b) of the statutes.

2. No later than April 1, 2008, the department and the legislative fiscal bureau shall submit the findings of the review under subdivision 1. to the appropriate standing committees of the legislature in the manner provided under section 13.172 (3) of the statutes, along with proposed legislation that does all of the following:

a. Creates, effective January 1, 2009, separate Medical Assistance appropriations for the state's share of benefits and administrative costs for the category of persons under paragraph (b) 1. a., along with the appropriate amounts in the schedule, and funds those appropriations from the health insurance purchasing trust fund.

b. Creates, effective January 1, 2009, separate appropriations for the state's share of benefits and administrative costs for the Badger Care health care program, along with the appropriate amounts in the schedule, and funds those appropriations from the health insurance purchasing trust fund.

c. Modifies, effective January 1, 2009, the Medical Assistance and Badger Care health care program appropriations in current law that are affected by the creation of the appropriations under subdivision 2. a. and b., along with the amounts in the schedule, to account for the creation of the appropriations under subdivision 2. a. and

b., and funds the modified appropriations in the same manner as those appropriations are funded under current law.

SECTION 15. Initial applicability.

(1) HEALTH SAVINGS ACCOUNTS. The treatment of sections 71.83 (1) (ce) and subchapter XVI of chapter 71 of the statutes first applies to taxable years beginning on January 1, 2008.

(END)