RESEARCH APPENDIX - Draft Transfer/Copy Request Form

- Atty's please complete this form and give to Mike Barman

(Request Made By: PJK) (Date: 5 / 5 / 05)

○ ☞ Please transfer the drafting file for

2003 LRB ______ to the drafting file

for **2005 LRB** ______

Done JMB

☞ The final version of the 2003 draft and the final Request Sheet will copied on yellow paper, and returned to the original 2003 drafting file. A new cover sheet will be created/included listing the new location of the drafting file's "guts".

☞ For research purposes, because the 2003 draft was incorporated into a 2005 draft, the complete drafting file will be transferred, as a separate appendix, to the new 2005 drafting file. This request form will be inserted into the "guts" of the 2005 draft. If introduced, the appendix will be scanned/added to the electronic drafting file folder.

--OR--

☒ ☞ Please copy the drafting file for

2005 LRB 0950 / all (include the version) and place it in the

drafting file for **2005 LRB** 2922

☞ For research purposes, because the original 2005 draft was incorporated into another 2005 draft, the original drafting file will be copied on yellow paper (darkened/auto centered/reduced to 90%) and added, as a separate appendix, to the new 2005 drafting file. This request form will be inserted into the "guts" of the new 2005 draft. If introduced the appendix will be scanned/added to the electronic drafting file folder.

☞ The original drafting file will then returned, intact, to its folder and filed. For future reference, a copy of the transfer/copy request form will also be added to the "guts" of the original draft.

Updated: 08/26/2004

A. Policy:

The Corporation shall establish and operate a program under which participants shall be assigned a Health Insurance Purchasing Account, shall use the Account to purchase health insurance from competing qualifying health care plans, and shall have a clear financial incentive to choose the health care plans that on a risk-adjusted basis provide health insurance at the lowest-cost and of the highest quality.

The Department of Revenue shall collect an assessment from employers to finance the program, and (after deducting a fee equal to the cost of collection **plus any amount needed to finance the state share of the "family" portion of Medicaid and the state share of BadgerCare**) shall remit the assessment amounts collected to the Corporation.

The Corporation shall pay to the Department of Health and Family Services an amount equal to the cost, less the federal match, of providing health care to Wisconsin residents enrolled in the family portion of Medicaid and BadgerCare until the waiver discussed below is approved and goes into effect.

The Department of Health and Family Services **and the Corporation shall jointly develop a plan under which Wisconsin residents who are eligible for the family portion of Medicaid and BadgerCare may also be assigned Accounts and under which the cost of their Accounts shall qualify for an acceptable federal match, and the Department of Health and Family Services** shall seek a waiver from the U.S. Department of Health and Human Services **to implement this plan.**

B. Definitions:

(1) Corporation: Health Insurance Purchasing Corporation of Wisconsin, a private corporation governed by a 8-person Board of Directors that's responsible for establishing and operating the health insurance purchasing program. Board members include: 1 person chosen by WMC, 1 person chosen by MMAC, 1 person chosen by WFIB, 1 person chosen by AFL-CIO, 1 person chosen by the union with the largest membership in Wisconsin, 1 person chosen by Farm Bureau, 1 person chosen by Farmers Union, and 1 person chosen by Governor to represent consumers. All major Board decisions require 7 votes. Board meetings would be held in public, unless open-meetings type exceptions apply. Legislative Audit Bureau would be required to conduct a comprehensive audit at least once every two years, and would have access to all Board meetings and records. Board would be required to submit annual report to Legislature. Board would be responsible for choosing and overseeing Executive Director and other staff, and approving all major contracts.

(2) Participants:

(a) Wisconsin residents aged 0 through 64 who have resided in Wisconsin for at least six months and are not institutionalized.

(b) Children born to such persons in Wisconsin.

(c) **Exludes** Wisconsin residents who are eligible for Medicaid or BadgerCare through the existing Medicaid & BadgerCare programs until the waiver is approved and goes into effect.

(d) Excludes federal employees.

(3) Health Insurance Purchasing Account: Includes:

(a) A Health Savings Account (HSA), into which, for participants aged 21-64, the Corporation shall deposit $600 per year; and

(b) A Premium Credit, the dollar value of which has been actuarially adjusted for age, sex, and other appropriate risk factors, which the participant shall use to buy health insurance and shall direct the Corporation to transfer to the participants' choice of a qualifying health insurance plan.

(c) The Corporation may retain a percentage of the Premium Credits of participants, and pay the amount retained to any health care plan that (despite the actuarial adjustment of Premum Credits for age, sex, and other appropriate risk factors) has incurred disproportionate risk.

(d) An Account shall be: (i) opened for every Wisconsin resident who is less than 65 years of age and has resided in Wisconsin for at least 6 months (as well as for a dependent child who is born in Wisconsin to another Wisconsin resident for whom an Account has been created, in which case the child shall have the Account created at birth), (ii) deactivated for any person who claims residency in another state or jurisdiction for Wisconsin income tax purposes, or for any Wisconsin resident who is eligible for Medicaid or BadgerCare until the waiver request to the U.S. Department of Health and Human Services is approved, (iii) reactivated for any person who acknowledges residency in Wisconsin for Wisconsin income tax purposes, or for any person eligible for Medicaid or BadgerCare once the waiver request to the U.S. Department of Health and Human Services has been approved, and (iv) closed for any person who dies prior to age 65 or turns 65.

(4) Health insurance: Includes medical care, hospital care, and prescription drugs, subject to the following cost sharing and pre-existing condition limitation:

(a) No cost sharing for preventive care as defined by the Corporation (including well-baby care, annual medical exams for children 0-18, medically indicated immunizations, annual gynecological exams for older girls and women, medically indicated pap smears and mammograms, annual medical exams for older men, medically indicated colonoscopies) or emergency care as defined by the Corporation.

(b) Otherwise, the following cost sharing applies:

(i) For persons 21-64:

- an annual deductible of $1,200
- co-pays for doctors' visits of $25/visit or $35/visit for specialists
- co-pays for prescription drugs of $5 for generic drugs, $15 for "preferred" brand drugs, and $35 for non-preferred brand drugs (as in current State Employee Health Plan)
- a $250 co-pay for non-emergency use of hospital emergency rooms

(ii) For persons 0-20:

• an annual deductible of $100
•co-pays for doctors' visits of $10/visit or $15/visit for specialists
•co-pays for prescription drugs of $5 for generic drugs, $15 for "preferred" brand drugs, and $35 for non-preferred brand drugs (as in current State Employee Health Plan)
• a $250 co-pay for non-emergency use of hospital emergency rooms

(c) Total cost-sharing would be capped at $2,000/adult/year and $1,000/child/year.
(d) In the case of participants who, during the 12 months prior to enrolling as participants, resided in another country or U.S. state in which they did not have health insurance that provided coverage substantially similar to the health insurance provided by this program, pre-existing medical conditions would not be covered by the health insurance provided by this program.
(e) The Corporation shall retain the portion of participants' Premium Credits that has been actuarially allocated for the provision of prescription drug coverage and use that portion to assume the risk for, and pay directly for, prescription drugs used by participants. Provided, however, that if the Corporation determines that this method of prescription drug coverage is not cost-effective, the Corporation may include the portion of participants' Premium Credits that has been actuarially allocated for the provision of prescription drug coverage in the dollar value of the Premium Credits that participants direct the Corporation to transfer to the participants' choice of a qualifying health insurance plan, and then require all qualifying health insurance plans to assume the risk for, and pay directly for, prescription drugs used by participants.

(5) Qualifying health care plans: Insurers (whether HMOs, PPOs, or indemnity carriers) licensed to sell health insurance in Wisconsin that the Corporation has determined meet the financial, coverage, and disclosure standards comparable to those that the Wisconsin Department of Employee Trust Funds has used in qualifying health care plans under the state employee health plan.

(6) Assessment. The assessment shall be as follows:

(a) In the case of employers who file quarterly federal tax form 941 (or its equivalent), the assessment shall not exceed the following percentage of Medicare wages as reported on the form:

(i) 8% of the 1st $100,000 of Medicare wages
(ii) 9% of the 2nd $100,000 of Medicare wages
(iii) 10% of the 3rd $100,000 of Medicare wages
(iv) 11% of the 4th $100,000 of Medicare wages
(v) 12% of all remaining Medicare wages

An employer who, on 1/1/07, has in effect a collective bargaining agreement with a union that provides for health insurance coverage may exclude from the Medicare

wages that are subject to this assessment the wages of any employee who is covered by the agreement.

(b) In the case of self-employed individuals or farmers who file annually federal tax forms C or F, and consequently file federal form SE, the assessment shall not exceed the following percentage of Medicare wages as reported on form SE:

(i) 8% of the 1st $100,000 of Medicare wages
(ii) 9% of the 2nd $100,000 of Medicare wages
(iii) 10% of the 3rd $100,000 of Medicare wages
(iv) 11% of the 4th $100,000 of Medicare wages
(v) 12% of all remaining Medicare wages

(c) In the case of individuals whose earnings from Wisconsin employers is less than $10,000 if filing singly or $20,000 if married and filing jointly, but whose Adjusted Gross Income (AGI) is more than $20,000 if filing singly or $40,000 if married but filing jointly, a special assessment shall be imposed that equals the lesser of: (i) 10% of the difference between AGI and Wisconsin earnings, or (ii) $2,000 if filing singly or $4,000 if married and filing jointly.

(d) The assessment shall be administered and collected by the Wisconsin Department of Revenue, which (after deducting (i) reasonable administrative costs and (ii) any amount needed to finance the state share of the "family" portion of Medicaid and the state share of BadgerCare until the federal waiver request to the U.S. Department of Health and Human Services is approved) shall remit the balance to the Corporation.

(e) To ensure that the assessment revenue collected from employers, at the level specified in this legislation, approximately equals to estimated cost of the two components of the Health Insurance Purchasing Accounts for all participants in the program plus reasonable administrative costs and a reasonable level of reserves, the Corporation would have the authority to (i) increase the amount in HSAs by up to 50% if the Corporation estimates that revenues will exceed costs or (ii) reduce health insurance benefits by 5% if the Corporation estimates that costs will exceed revenues.

(f) If the Corporation determines, based on information and recommendations received from its actuaries, that the assessment will not generate sufficient funds to pay for the health insurance benefits described above even after such benefits are reduced by 5%, the Corporation shall inform the Legislature and Governor, indicate what changes in the assessment would be required to maintain the same benefit level, indicate what alternative reductions in benefits would be appropriate in order to avoid an increase in the assessment, and recommend which of these alternative reductions in benefits the Corporation prefers. The recommended reduction in benefits will take effect unless the Legislature and Governor enact legislation that requires a different resolution of the problem.

(7) Employers. Any entity that is required under federal law to file form 941 and any entity or person that is required under federal law to file schedule SE.

(8) Family portion of Medicaid. The portion of Medicaid that does *not* provide services to the elderly or disabled, but provides services to low-income families.

(9) BadgerCare. The BadgerCare program implemented under the federal SCHIP legislation.

C. Effective dates

(1) The Corporation shall begin to function immediately upon passage of the legislation.

(2) The Corporation shall assign participants to Accounts beginning 1/1/06

(3) Participants shall have an open enrollment period, during which they use their Accounts to choose a qualifying health care plan, every November, beginning 11/06.

(4) Participants' health insurance coverage under the qualifying health care plans they've chosen shall take effect on January 1, beginning 1/1/07.

(5) The Department of Revenue shall begin to collect assessments from employers beginning with the first quarter of 2007.

* (6) The Corporation shall begin to pay the Department of Health and Family Services for the state share of the family portion of Medicaid and BadgerCare beginning 1/1/07, and shall continue to make such payments until the waiver is granted and goes into effect.

(7) The Department of Health and Family Services shall submit its waiver request to the U.S. Department of Health and Human Services no later than 7/1/06.

see comment #2 to D-note on P1; they want the assessment to begin a quarter sooner than represented here to have $ before coverage begins in 2007.

Kahler, Pam

From: Kostelic, Jeff
Sent: Monday, May 16, 2005 12:44 PM
To: Kahler, Pam
Subject: RE: Richards Health Care legislation

Pam,

I hear that you have completed much of your work on Representative Richards' health care reform proposal. Thank you for tackling this project. I really appreciate your hard work and willingness to make this a priority.

I have a request relating to collective bargaining units. The instructions provided to you state that the legislation would take affect upon expiration of existing collective bargaining agreements. Representative Richards would like to add (if you haven't done so already) "of if both parties agree to re-open negotiations".

Finally, would it be possible to review your portion of this draft while we wait for your colleagues to complete their work?

Thanks.

Jeff Kostelic
Office of Representative Jon Richards
266-0650

not included !!

Kahler, Pam

From: Lisa Ellinger [lisa_ellinger@yahoo.com]

Sent: Friday, June 03, 2005 6:38 AM

To: Kahler, Pam

Cc: Reinemann, John; Kostelic, Jeff; David Riemer

Subject: LRB draft

Pam:

David and I went through your first draft of LRB 2922. We have attempted to answer your questions, and came up with a few of our own. We are still going over some revisions for pages 8-10, which I will send you in another email, but I wanted to give you what we have at this point so that we can continue to move forward on the draft.

Our comments follow. Please call with any questions.

Jeff & John, if you have issues with any of these comments, please forward corrections or questions to Pam, David and I.

Lisa Ellinger
The Wisconsin Health Project
414-534-4521

Comments on the Drafter's Note:
1. Our preference is to give leave constitutionally delegated legislative authority with the Legislature, rather than charging a state agency with these responsibilities.

On the residency issue, we want to incorporate whatever state law currently allows the University System to designate resident and non-res categories for students.

2. Borrowing v. assessment sooner v. coverage later – we prefer option "b," eg, starting the assessment a quarter earlier.

4. Our preference would be to grant HIPCo the authority to establish an independent, binding appeals process, rather than put this in the hands of a state agency. See the language below listed for page 5, Line 20.

5. Your assumptions here seem appropriate to us.

Comments on the Bill Draft
Pg 1
All looks good

Pg 2
Line 3 – Do you think it is necessary to further define "low-income" (ie, non-elderly, non-disabled)?

Pg 3
Lines 7-11 – the definition of "legally domiciled" strikes us as limiting. We would prefer to delete all text after "state" on Line 7 through Line 11 and add the words "as defined by the corporation."
We also would like to ensure that non-resident UW System students are not covered in this system, and would like to know if the private colleges have a similar designation for students from out-of-state.
Do feel this language sufficiently addresses the "snowbird" issue – people who live out of Wisconsin more than 6 months each year for income tax purposes. We want to make sure they are not covered by

this program as well.

Pg 4
Lines 5-17 (&21) – a few changes to the makeup of the Board:
Line 5 – change to 9 directors
Line 10 – Metro should be Metropolitan
Line 14 – change to the Wisconsin Technology Council
Line 15 – change to the SEIU Wisconsin State Council
Line 17 – change to 2 gubernatorial appointees
Line 18 – change to 4-year terms
Line 21 – change to 8 votes
End Note: Change to state that ALL decisions need a supermajority vote rather than defining "major" decisions. And add this language at the end of line 22 – "unless the Board agrees to allow designated categories of decisions to be made by a simple majority."

Pg 5
Lines 6-8 – do you feel this allows HIPCo to contract out these functions to competing vendors. If not, please add language similar to the prescription drug carve out on page 8.
Lines 9-11/Note: Delete this provision.
Lines 12-13 – we want this to read similar to open records law that currently applies to ETF. Please let us know whether that agency is exempt in any way from that law.
Line 20 (new language, item 2(g) – this is where we propose adding language on the appeals process: "Establish an independent and binding appeals process to to resolve disputes over eligibility and other determinations made by the corporation."

Pg 6
mid-page Note: The answer is yes, the consumer pay have to pay out-of-pocket, depending on their health plan selection.
Line 13 – you ask later in the draft about the enrollment of those turning 21. We want to keep this simple and dictate that participants enroll in the "adult" program the first year they will be 21 for the entire year.
Line 14 – change "consist of" to "include"
Line 16 – slight change/addition to account for the fact that federal HSA indexes what qualifies as a high deductible plan: "...health savings account. Beginning in 2008, the corporation shall adjust the amount deposited in each HSA to reflect inflation. If the corporation..."
This brings another question to mind. Do you feel this bill draft address the need for HIPCo to increase the deductible levels to comply with federal law? Is this something we should express more explicitly?
Line 18 - "not to exceed $300..." change to "not to exceed the maximum amount allowable under federal law."
Note: The answer is yes...with the same limitations I just described.
Line 21 – change "despite" to "not fully reflected in"

Page 7
Looks good, no changes.

Page 8
Will send changes in a future email.

Page 9
Note: on turning 21 during the year... see comments from page 6, line 13. Will send addtional changes in a future email.

Page 10
Will send changes in a future email.

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Kahler, Pam

From: Lisa Ellinger [lisa_ellinger@yahoo.com]

Sent: Thursday, June 09, 2005 10:03 AM

To: Kahler, Pam

Subject: RE: Draft Revisions: The sequel

Yes, that's what I mean. Just drop me a note when you do have a feel for when it will be ready.

LE

"Kahler, Pam" <Pam.Kahler@legis.state.wi.us> wrote:

> Do you mean when I expect another draft to be ready? I really can't say. We are completing the budget sub right now. When Marc and Joe have finished their revenue portions, they will send the draft to me and I will complete my changes as soon as possible.
>
> -----Original Message-----
> **From:** Lisa Ellinger [mailto:lisa_ellinger@yahoo.com]
> **Sent:** Wednesday, June 08, 2005 9:35 PM
> **To:** Kahler, Pam
> **Subject:** RE: Draft Revisions: The sequel
>
> Pam:
>
> Thanks for the response. Please let me know when you have an estimated date for completion.
>
> Lisa
>
> ***"Kahler, Pam" <Pam.Kahler@legis.state.wi.us>*** wrote:
>
>> Lisa:
>>
>> I know that Marc Shovers had started working on the revenue portion before your first e-mail with changes arrived. I intend to address all of your changes when Marc and Joe Kreye finish the revenue portion. They haven't been able to finish it yet, however. This week is supposed to be the final wrap-up of the Joint Finance deliberations on the budget, so we will all be busy with drafting for the Joint Finance substitute amendment. I don't think that Thursday would be useful for a meeting on the draft, because of the status of our budget drafting.
>>
>> -----Original Message-----
>> **From:** Lisa Ellinger [mailto:lisa_ellinger@yahoo.com]
>> **Sent:** Tuesday, June 07, 2005 1:05 PM
>> **To:** Kahler, Pam
>> **Cc:** Reinemann, John; Kostelic, Jeff; David Riemer
>> **Subject:** Draft Revisions: The sequel
>>
>> Pam:
>>
>> Here are the rest of our comments on LRB 2922. Please call with any questions. Also, please let me know the status on the "Revenue"

portion of the bill draft.

David and I are going to be in Madison on Thursday (6/) and will be available after 3pm if you would find a face-to-face meeting useful. Let me know.

Jeff & John, as always, let me know if we missed anything and forward corrections or questions to Pam, David and I.

Lisa Ellinger
The Wisconsin Health Project
414-534-4521

First, one major overall change. Please change the references for age determinations for the HSAs. We originally said 21. Please make it 18. We learned that in our budgeting, money for HSAs was allocated for the 200k adults in the MA/BadgerCare program. In the first phase of the program, that population will still be in MA/BC and not be eligible for HSAs. Therefore, this "frees up" enough money to provide HSAs for the 200k adults aged 18-21. Having enrollees considered "adults" at age 18 will make this proposal more consistent with other programs' eligiblity determinations, such as MA.

Page 8
Lines 1-5: Pam, do you feel this language sufficiently expresses the ability of HIPCo to contract out these responsibilities? Delete the word "directly" in line 2.
Lines 12-14/Note: Eliminate "by up to 5% in a year." The Board would increase cost-sharing through the supermajority vote required. We want the board to have the authority to determine the reduction, whether they opt to decrease the HAS, enhance the cost-sharing, or a combination of both. I am re-sending section 6(f) from the specs, which describes what we are looking for here (ignore the 5% reference, we have have decided to remove):
"If the Corporation determines, based on information and recommendations received from its actuaries, that the assessment will not generate sufficient funds to pay for the health insurance benefits described above even after such benefits are reduced by 5%, the Corporation shall inform the Legislature and Governor, indicate what changes in the assessment would be required to maintain the same benefit level, indicate what alternative reductions in benefits would be appropriate in order to avoid an increase in the assessment, and recommend which of these alternative reductions in benefits the Corporation prefers. The recommended reduction in benefits will take effect unless the Legislature and Governor enact legislation that requires a different resolution of the problem."
Line 16 – already relayed our thoughts on eligibility in the previous email.
Line 19 – we would like to insert new language, allowing HIPCo to opt for a system of co-insurance, rather than the co-pays. We have been getting a lot of feedback from the insurance industry and others

that this is a better system in terms of ease-of-administration and also for enhancing the effect of the consumer incentives. Here is the language we would like to add as (b): "A designated percentage of the cost of covered benefits, to be determined by the Corporation, unless the Corporation decides instead to apply co-pays such as those described in (c), (d), (e), and (f).
Lines 23-24 – please note that non-emergency use will be defined by HIPCo.

Page 9
Line 8 – same as stated above for Line 19 on Page 8.
Lines 12-13 - same as stated above for Lines 23-24 on Page 8.
Note: on turning 21 (now 18) during the year... addressed in my previous email.
Line 22 – Pam, I believe I asked in my previous email whether you felt we needed to address the fact that federal HAS law indexes the required deductible. Following is language that could be inserted as item (4) to address this issue: "Inflation adjustment. Beginning in 2008, the Corporation shall adjust the deductibles under (1)(a) and (2)(c), the co-pays under (1)(c)(d)(e)(f) and (2)(c)(d)(e)(f), and the maximum amounts under (3) to reflect inflation."
Line 22 – new language on pre-existing conditions. "(1) Subject to (2), a health beneift..." – continue with existing language.

Page 10
Line 2 – change "in another state or country" to "outside of Wisconsin"
Line 4 – add "as defined by the Corporation." at the end of the sentence.
New language to "phase in" those with pre-exsiting conditions: "(2) The pre-existing conditions in (1) shall end once an eligible resident has been covered by this program for 36 months.
Note: We think the language as written is fine. No need to change to 18 months.
Note 2: You are correct, initially those in MA/BadgerCare would not be "eligible" for this program.

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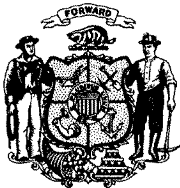


State of Wisconsin
2005 – 2006 LEGISLATURE

LRB-2922/P1
PJK/JK/MES:wlj:ch

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to create*** 13.94 (1s) (c) 4., 20.855 (8m), 25.17 (1) (gd), 25.775 and chapter 260 of the statutes; **relating to:** creating the Health Insurance Purchasing Corporation of Wisconsin, establishing a health insurance purchasing arrangement through the use of private accounts for all state residents, and making an appropriation.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

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

SECTION 1. 13.94 (1s) (c) 4. of the statutes is created to read:

13.94 **(1s)** (c) 4. The Health Insurance Purchasing Corporation of Wisconsin for the cost of the audits required to be performed under s. 260.05 (3).

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

20.855 **(8m)** HEALTH INSURANCE PURCHASING CORPORATION OF WISCONSIN. (r) *Health insurance purchasing accounts and administration.* After deducting the

1 amounts appropriated under s. 20.XXX (X) (X), the amounts appropriated for the
2 state's share of administrative costs and benefits under the Medical Assistance
3 program that are attributable to low-income families, and the amounts
4 appropriated for the state's share of administrative costs and benefits under the
5 Badger Care health care program under s. 49.665, the balance of the moneys paid
6 into the health insurance purchasing trust fund to be paid to the Health Insurance
7 Purchasing Corporation of Wisconsin for establishing, funding, and managing, and
8 assisting individuals with the use of, the health insurance purchasing accounts
9 established under ch. 260.

****NOTE: The reference to the appropriation section will be DOR's administrative expenses.

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

11 25.17 **(1)** (gd) Health insurance purchasing trust fund (s. 25.775);

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

13 **25.775 Health insurance purchasing trust fund.** There is established a
14 separate, nonlapsible trust fund designated as the health insurance purchasing
15 trust fund, consisting of all moneys collected under s. 260.XX.

****NOTE: The section with the "Xs" will be the section that provides for the assessment.

16 **SECTION 5.** Chapter 260 of the statutes is created to read:

17 **CHAPTER 260**

18 **HEALTH INSURANCE PURCHASING ACCOUNTS**

19 **260.01 Definitions.** In this chapter:

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

21 **(2)** "Corporation" means the Health Insurance Purchasing Corporation of
22 Wisconsin.

; as defined by the corporation,

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

3 (a) The individual has been legally domiciled in this state for at least 6 months,
4 except that, if a child is under 6 months of age, the child is an "eligible resident" if
5 the child lives in this state and at least one of the child's parents or the child's
6 guardian has been legally domiciled in this state for at least 6 months. For purposes
7 of this chapter, legal domicile is established by living in this state and doing any of
8 the following:

9 1. Obtaining a Wisconsin motor vehicle operator's license.

10 2. Registering to vote in Wisconsin.

11 3. Filing a Wisconsin income tax return.

12 (b) The individual is under 65 years of age.

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

17 (d) Unless a waiver requested under s. 260.60 (2) is granted and in effect, the
18 individual is not eligible for medical assistance under subch. IV of ch. 49 or for health
19 care coverage under the Badger Care health care program under s. 49.665.

20 **260.05 Health Insurance Purchasing Corporation of Wisconsin. (1)**
21 INCORPORATION. The secretary of administration shall do all of the following:

22 (a) Draft and file articles of incorporation for a nonstock corporation under ch.
23 181 and take all actions necessary to exempt the corporation from federal taxation
24 under section 501 (c) (3) of the Internal Revenue Code.

1 (b) Provide in the articles of incorporation filed under par. (a) all of the
2 following:
3 1. That the name of the corporation is the "Health Insurance Purchasing
4 Corporation of Wisconsin."
5 2. That the board shall consist of 8 directors who, except for the initial directors,
6 shall be designated or appointed as follows:
7 a. One designated by Wisconsin Manufacturers and Commerce.
8 b. One designated by the Wisconsin State American Federation of Labor and
9 Congress of Industrial Organizations.
10 c. One designated by the Metro Milwaukee Association of Commerce.
11 d. One designated by the Wisconsin office of the National Federation of
12 Independent Business.
13 e. One designated by the Wisconsin Farm Bureau Federation.
14 f. One designated by the Wisconsin Farmers Union.
15 g. One designated by the labor union with the largest membership in
16 Wisconsin, as specified by the secretary of administration.
17 h. One designated by the governor to represent consumers.
18 3. That the term of a director shall be 6 years, except that the term of an initial
19 director shall be one year.

****NOTE: Do you still want to specify 6–year terms?

20 4. The names and addresses of the initial directors.
21 5. That 7 votes shall be necessary for adoption of any major decision of the
22 board.

****NOTE: Do you want to be more specific about what a major decision is, or do you think that everyone will agree on what is major?

1 (c) In consultation with the persons charged with designating the directors
2 under par. (b) 2. a. to h., designate the initial directors.
3 (d) Draft bylaws for adoption by the board.
4 **(2)** DUTIES. As a condition for the release of funds under s. 20.855 (8m) (r), the
5 corporation shall do all of the following:
6 (a) Establish, fund, and manage health insurance purchasing accounts in the
7 manner provided in this chapter and assist eligible residents in using their accounts
8 to purchase health care coverage.
9 (b) Expend in a state fiscal year in costs to administer the health insurance
10 purchasing accounts not more than 1 percent of the amount appropriated under s.
11 20.855 (8m) (r) for that state fiscal year.

****NOTE: Do you still want this provision? Referencing the maximum amount that may be spent in a state fiscal year does not obligate the corporation to use the same fiscal year as the state. You could use a different measure, however, if you wish.

12 (c) Keep its records open at all times to inspection and examination by the
13 governor or any committee of either or both houses of the legislature.
14 (d) Keep its meetings open to the public to the extent required of governmental
15 bodies under subch. V of ch. 19.
16 (e) Cooperate with the legislative audit bureau in the performance of the audits
17 under sub. (3).
18 (f) Submit on each October 1 an annual report to the legislature under s. 13.172
19 (2) and to the governor regarding its activities.
20 **(3)** AUDITS. At least once every 2 years, the legislative audit bureau shall
21 conduct a financial audit of the corporation and a performance evaluation audit of
22 the health insurance purchasing arrangement under this chapter that includes an
23 audit of the corporation's policies and management practices. The legislative audit

1 bureau shall distribute a copy of each audit report under this subsection to the
2 legislature under s. 13.172 (2) and to the governor. The corporation shall reimburse
3 the legislative audit bureau for the cost of the audits and reports required under this
4 subsection.

5 **260.10 Health insurance purchasing accounts.** **(1)** ESTABLISHMENT AND
6 FUNDING. (a) Beginning in January 2006, the corporation shall establish a private,
7 health insurance purchasing account for each eligible resident. Beginning in 2007,
8 the corporation annually shall credit each account with a premium amount that is
9 actuarially adjusted for the eligible resident based on age, sex, and other appropriate
10 risk factors determined by the board. Subject to sub. (2) and s. 260.20 (3), the
11 corporation shall pay the amount credited under this paragraph to the health benefit
12 plan selected by the eligible resident under s. 260.15 (2).

****NOTE: Is this the entire premium, or could an individual have to pay something out–of–pocket?

13 (b) For eligible residents who are at least 21 years of age, each health insurance
14 purchasing account shall also ~~consist of~~ include a health savings account, as described in 26
15 USC 223. Beginning in 2007, the corporation shall deposit $600 annually into each
16 health savings account, except that, if the corporation estimates that revenues will
17 exceed costs in a year, the corporation may deposit an additional amount, not to
18 exceed $300 per year, into each health savings account.

****NOTE: May an eligible resident also make deposits into his or her HSA?

Insert 6–18

19 **(2)** ADDITIONAL PAYMENT FOR DISPROPORTIONATE RISK. The corporation may retain
20 a percentage of the amounts credited under sub. (1) (a) to pay to health benefit plans
21 that have incurred disproportionate risk, despite the actuarial adjustment in the
22 amount credited to each account under sub. (1) (a).

not fully compensated for by

1 **260.15 Health benefit plans.** **(1)** PARTICIPATION OF INSURERS. (a) The
2 corporation shall solicit bids from, and enter into contracts with, insurers for
3 providing coverage to eligible residents. Any insurer that is authorized to do
4 business in this state in one or more lines of insurance that includes health insurance
5 is eligible to submit a bid.

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

10 **(2)** PLAN SELECTION. Beginning in 2006, the corporation shall offer an annual
11 open enrollment period in November during which each eligible resident shall select
12 a health benefit plan from among those offered. Coverage under the health benefit
13 plan that an eligible resident selects in November shall be effective on the following
14 January 1.

15 **260.20 Benefits.** **(1)** GENERALLY. Coverage under this chapter shall begin on
16 January 1, 2007, and shall include medical and hospital care coverage and
17 prescription drug coverage.

18 **(2)** BENEFITS WITHOUT COPAYMENTS. Notwithstanding s. 260.25, cost–sharing
19 shall not apply to coverage of emergency care, as defined by the corporation, or to
20 coverage of certain preventive services or procedures, as determined by the
21 corporation, but including well–baby care, annual medical examinations for children
22 up to 18 years of age, medically indicated immunizations, annual gynecological
23 examinations for older girls and women, medically indicated Papanicolaou tests and
24 mammograms, annual medical examinations for older men, and medically indicated
25 colonoscopies.

(3) PHARMACY BENEFIT. (a) Except as provided in par. (b), the corporation shall assume the risk for, and directly 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 benefit 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 benefit plans.

(4) BENEFIT REDUCTION. If the corporation estimates that costs will exceed revenues, the corporation may reduce benefits under this section by up to 5 percent in a year.

****NOTE: How would this reduction occur?

260.25 Cost–sharing. (1) PERSONS AT LEAST 21 YEARS OF AGE. Subject to sub. (3), an eligible resident who is 21 years of age or older shall pay the following cost–sharing amounts:

(a) An annual deductible of $1,200.

(b) Except as provided in par. (c), a copayment of $25 for each visit to a clinic or physician's office.

(c) A copayment of $35 for each visit to a specialist, as determined by the corporation.

(d) A copayment of $250 for each nonemergency use of hospital emergency facilities.

1 (e) A copayment of $5 for each prescription of a generic drug, a copayment of
2 $15 for each prescription of a brand–name drug that is on the preferred list
3 determined by the corporation, and a copayment of $35 for each prescription of a
4 brand–name drug that is not on the preferred list determined by the corporation.

5 **(2)** PERSONS UNDER 21 YEARS OF AGE. Subject to sub. (3), an eligible resident who
6 is under 21 years of age shall pay the following cost–sharing amounts:

7 (a) An annual deductible of $100.

8 (b) Except as provided in par. (c), a copayment of $10 for each visit to a clinic
9 or physician's office.

10 (c) A copayment of $15 for each visit to a specialist, as determined by the
11 corporation.

12 (d) A copayment of $250 for each nonemergency use of hospital emergency
13 facilities.

14 (e) A copayment of $5 for each prescription of a generic drug, a copayment of
15 $15 for each prescription of a brand–name drug that is on the preferred list
16 determined by the corporation, and a copayment of $35 for each prescription of a
17 brand–name drug that is not on the preferred list determined by the corporation.

18 **(3)** MAXIMUM AMOUNTS. An eligible resident who is 21 years of age or older may
19 not be required to pay more than $2,000 per year in total cost–sharing under sub. (1).
20 An eligible resident who is under 21 years of age may not be required to pay more
21 than $1,000 per year in total cost–sharing under sub. (2).

****NOTE: How will the deductible and maximum out–of–pocket amounts be handled for someone who turns 21 during the year?

22 **260.30 Preexisting condition exclusion.** A health benefit plan may not
23 provide coverage for any preexisting condition, as defined by the corporation, of an

1 eligible resident who, at any time during the 12–month period before becoming an
2 eligible resident, resided in another state or country and who did not have health
3 insurance coverage that was substantially similar to the coverage provided under
4 this chapter.

****NOTE: Is this consistent with your intent for this provision? Keep in mind that, as currently drafted, a person must live in Wisconsin for 6 months before he or she becomes an eligible resident and has coverage under this chapter, so maybe 12 months should be increased to 18 months.

5 **260.60 Including certain residents who are eligible for Medical**
6 **Assistance. (1)** PLAN. The corporation and the department of health and family
7 services shall jointly develop a plan for providing health care coverage under the
8 health insurance purchasing arrangement established under this chapter to
9 individuals who satisfy the criteria under s. 260.01 (3) (a) to (c) and who are eligible
10 for medical assistance under subch. IV of ch. 49 or for health care coverage under the
11 Badger Care health care program under s. 49.665.

****NOTE: Does the definition of "eligible resident" under s. 260.01 (3) (a) to (c) automatically exclude those persons who are eligible for MA based on age or disability?

12 **(2)** WAIVER REQUEST. The department of health and family services shall, no
13 later than July 1, 2006, request waivers from the secretary of the federal department
14 of health and human services for all of the following purposes:
15 (a) To implement the plan developed under sub. (1).
16 (b) To allow the use of federal financial participation to fund, to the maximum
17 extent possible, health care coverage under the arrangement established under this
18 chapter for individuals specified in sub. (1).
19 **(3)** PROPOSED LEGISLATION. If the waivers requested under sub. (2) are granted,
20 the department of health and family services shall submit to the appropriate

1 standing committees under s. 13.172 (3) proposed legislation that will implement the
2 provisions approved under the waivers.

3 **SECTION 6. Nonstatutory provisions.**

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

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

8 (b) *Eligibility categories for Medical Assistance.*

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

12 a. Low–income families.

13 b. Elderly or disabled persons.

14 2. No later than April 1, 2006, the department shall submit the findings of its
15 review under subdivision 1. to the appropriate standing committees of the
16 legislature in the manner provided under section 13.172 (3) of the statutes. If the
17 department determines that one or more statutory provisions provide eligibility
18 criteria that apply to both categories of persons under subdivision 1., along with its
19 findings the department shall submit proposed legislation specifying eligibility
20 criteria for Medical Assistance that clearly separates the 2 categories of persons
21 under subdivision 1. so that any single statutory unit applies to only one of the 2
22 categories.

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

24 1. The department and the legislative fiscal bureau shall review the following
25 Medical Assistance and Badger Care health care program appropriations to

1 determine what amount of each of the total amounts appropriated under each of the
2 appropriations is attributable to benefits provided to, or the administrative costs of
3 providing benefits to, Medical Assistance recipients in the category under paragraph
4 (b) 1. a. or Badger Care health care program recipients:

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

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

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

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

10 2. No later than April 1, 2006, the department and the legislative fiscal bureau
11 shall submit the findings of the review under subdivision 1. to the appropriate
12 standing committees of the legislature in the manner provided under section 13.172
13 (3) of the statutes, along with proposed legislation that does all of the following:

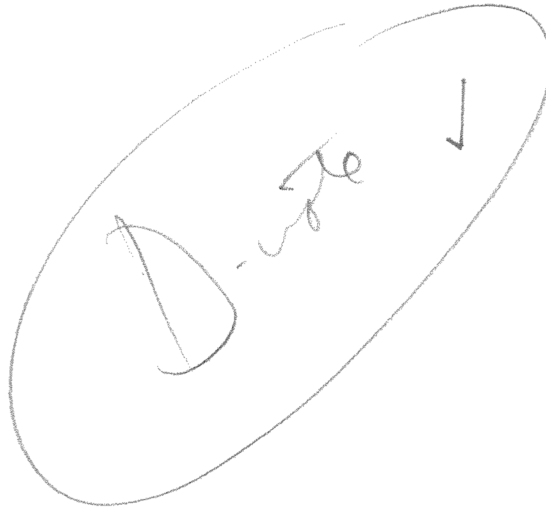
14 a. Creates, effective January 1, 2007, separate Medical Assistance
15 appropriations for the state's share of administrative costs and benefits for the
16 category of persons under paragraph (b) 1. a., along with the appropriate amounts
17 in the schedule, and funds those appropriations from the health insurance
18 purchasing trust fund.

19 b. Creates, effective January 1, 2007, separate appropriations for the state's
20 share of administrative costs and benefits for the Badger Care health care program,
21 along with the appropriate amounts in the schedule, and funds those appropriations
22 from the health insurance purchasing trust fund.

23 c. Modifies, effective January 1, 2007, the Medical Assistance and Badger Care
24 health care program appropriations in current law that are affected by the creation
25 of the appropriations under subdivision 2. a. and b., along with the amounts in the

1 schedule, to account for the creation of the appropriations under subdivision 2. a. and
2 b., and funds the modified appropriations in the same manner as those
3 appropriations are funded under current law.

4 **(END)**



2005–2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2922/P1ins
PJK/JK/MES:wlj:ch

INSERT 4–22

1 , except for those designated categories of decisions, if any, that the board agrees
2 to adopt by a simple majority of the votes

(END OF INSERT 4–22)

INSERT 5–8

3 , and perform all other functions required of the corporation under this chapter

(END OF INSERT 5–8)

INSERT 5–9

4 2. Establish an independent and binding appeals process for resolving disputes
5 over eligibility and other determinations made by the corporation.

(END OF INSERT 5–9)

INSERT 5–13

****NOTE: ETF is subject to the open records law except with respect to individual personal information in records of the department. See s. 40.07. You could have the corporation be subject to the open records law with the same exception; you could have the corporation not be subject to the open records law at all; you could have the corporation be subject to the open records law with respect to only certain types of records, such as financial. Regardless, the corporation would be subject to HIPAA confidentiality requirements and ss. 51.30, 146.82, and 252.15.

(END OF INSERT 5–13)

INSERT 5–19

6 (b) The corporation may contract with other organizations, entities, or
7 individuals for the performance of any of its functions.

(END OF INSERT 5–19)

INSERT 6–18

Ins 6-18

1 (b) 1. The health insurance purchasing account of an eligible resident who is
2 at least 18 years of age shall also include a health savings account, as described in
3 26 USC 223. For an eligible resident who is under 18 years of age when his or her
4 health insurance purchasing account is established, his or her health insurance
5 purchasing account shall include a health savings account beginning in the year in
6 which the eligible resident is 18 years of age on January 1.

****NOTE: Is this ok? This would require inclusion of an HSA if the individual is 18 when his or her account is *established* even if he or she turned 18 after January 1. For those who are under 18 when their accounts are established, however, the HSA would not be added when they turn 18 but at the beginning of the year after they turn 18 (unless, of course, they turn 18 on January 1).

7 2. Beginning in 2007, the corporation annually shall deposit an amount into
8 each health savings account. In 2007, the amount deposited shall be $600. The
9 amount deposited in each year thereafter shall be adjusted to reflect the annual
10 percentage change in the U.S. consumer price index for all urban consumers, U.S.
11 city average, as determined by the U.S. department of labor, for the 12–month period
12 ending on December 31 of the preceding year.

13 3. If the corporation estimates that revenues will exceed costs in a year, the
14 corporation may deposit into each health savings account an amount in addition to
15 the amount deposited under subd. 2, but not to exceed the maximum amount allowed
16 under federal law.

(END OF INSERT 6–18)

INSERT 8–12

17 determines, based on information and recommendations received from its
18 actuaries, that the assessment/tax under s. XX.XX will not generate sufficient
19 moneys for providing the health care benefits under subs. (1) to (3), the corporation
20 shall inform the governor and the legislature of all of the following:

Ins 8-12 cont'd

****NOTE: I'm not sure whether the funding mechanism will be called an assessment or a tax and I don't know the statute number under which it will be imposed.

1 1. That the assessment/tax is insufficient.

2 2. What increase in the assessment/tax would be required to maintain the
3 current benefit level.

4 3. Alternative benefit reductions that would be appropriate to avoid an increase
5 in the assessment/tax.

6 4. The benefit reductions that the corporation prefers.

7 (b) Unless legislation is enacted that implements a different solution, the
8 corporation shall implement the benefit reductions under par. (a) 4.

(END OF INSERT 8–12)

INSERT 8–20

use twice

9 (NOT) , a percentage, to be determined by the corporation, of the cost of covered
10 benefits, unless the corporation decides to require copayments instead of
11 coinsurance

(END OF INSERT 8–20)

INSERT 9–4

use twice

12 (IL) (e) For each prescription of a generic drug, a copayment of $5; for each
13 prescription of a brand–name drug that is on the preferred list determined by the
14 corporation, a copayment of $15; and for each prescription of a brand–name drug that
15 is not on the preferred list determined by the corporation, a copayment of $35.

(END OF INSERT 9–4)

INSERT 9–21

16 (4t) **(4)** ADJUSTMENTS FOR INFLATION. Notwithstanding subs. (1) to (3), beginning in
17 2008, the corporation annually shall adjust the deductible, copayment, and

Ins 9-21 contd

1 maximum amounts to reflect the annual percentage change in the U.S. consumer
2 price index for all urban consumers, U.S. city average, as determined by the U.S.
3 department of labor, for the 12–month period ending on December 31 of the
4 preceding year.

****NOTE: This provision requires adjustment for all eligible residents, even those who do not have HSAs. Is this ok?

(END OF INSERT 9–21)

INSERT 10–4

5 (2) LENGTH OF EXCLUSION. A preexisting condition exclusion under sub. (1) may
6 not extend beyond 36 months after the eligible resident obtains coverage, and
7 remains continuously covered, under this chapter.

****NOTE: Although the residency issue is not yet resolved, this limit on preexisting condition exclusions would not apply to persons who reside in Wisconsin for only part of the year because they would not be continuously covered, correct? Or do you want the 36 months of coverage to be a total but not necessarily continuous?

(END OF INSERT 10–4)

INSERT 10–10

8 in the low–income families category, as determined under 2005 Wisconsin Act
9 .... (this act), section 6 (1) (b),

(END OF INSERT 10–10)

Drafter's Note
from the
Legislative Reference Bureau

LRB-2922/P1dn
PJK/JK/MES:wlj:ch

Defining eligibility, in terms of who is a "resident," seems to be a major area that is still unresolved. In your latest comments, you indicated that you wanted to incorporate the state law that allows the UW to designate resident and nonresident categories for students. The designation is not actually who is a resident and who is a nonresident, but who is exempt from the payment of nonresident tuition. See s. 36.27 (2). I don't think this statute lends itself very well to use in this draft for who is eligible, or not eligible, for the program. In addition, it would increase the eligibility waiting period from the current six months to one year. If you want to use it or any part of it, however, let me know how you want to modify it. If you want to specify that nonresident students at the UW system are not eligible, as you indicated, I could exclude from eligibility persons who are "not exempt from the payment of nonresident tuition under s. 36.27 (2)."

I can see the case for limiting eligibility for the program established in this draft to persons who have lived in the state for at least six months. From the caselaw it is often difficult to determine exactly why certain "benefits" may not be subject to any sort of waiting period while others may be. One aspect to consider, however, is whether the benefit may be obtained and then "used" elsewhere or whether the "benefit" is so essential a part of living that it can only be "used" where it is obtained, such as welfare benefits. In this case, I can see wanting to discourage someone from establishing a residence in this state just to get "free" treatment for a particular condition and then leaving the state immediately after getting the treatment. Also, the waiting period in this draft does not infringe on a person's right to travel in the way that a waiting period for welfare benefits does. Unlike welfare benefits, a person is not discouraged from moving here because they will be denied something for a period that they had before the move. A person who moves here is not being denied health care or health care coverage, just participation in a *particular* program of coverage for a period. During the first six months, a new resident who is not eligible for a public health care program, such as MA, may purchase coverage in the private market, keep his or her current coverage in effect, not have coverage but purchase health care services as needed, etc.

You asked about private colleges and the resident/nonresident issue. My understanding is that private colleges are not regulated with respect to tuition; they are free to do as they please. Tuition at private colleges is usually the same for all students, regardless of residence.

You also indicated that you do not want persons who do not live, or intend to live, here all year long to be eligible for the program. If that is the case, you will have to decide the length of time that is relevant for eligibility, i.e., the number of months, days, weeks, etc., that a person lives outside the state each year that makes the person ineligible for the program.

Since you want the corporation to decide what "legally domiciled" means, perhaps the corporation could decide these and other issues related to residence. You could specifically list a number of issues that you want the corporation to address when determining legal domicile, such as part–time residency each year in another state; attendance at a college or university (or another type of school) in the state, but residency in another state when not attending school; etc. Another suggestion is specifically excluding from the definition of "eligible resident" persons who are part–time residents, as determined by the corporation; persons who attend school in the state but who are residents of another state or country, as determined by the corporation; etc.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us