Inserts for P3 (PJK)

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LEGISLATIVE REFERENCE BUREAU

LRB–2922/P3ins
PJK/JK/MES:wlj:jf

INSERT 5–16

1 **(3)** CONTRACTS AND HIRING. (a) The corporation may contract with other
2 organizations, entities, or individuals for the performance of any of its functions.
3 With respect to contracts under this subsection, the corporation shall do all of the
4 following:
5 1. Use generally accepted procedures, which shall be in writing and open to
6 public inspection, for soliciting bids or proposals and for awarding contracts to the
7 lowest–bidding, qualified person or to the most qualified person submitting a
8 proposal.
9 2. Make open to public inspection all of its requests for bids or proposals, all of
10 its analyses of bids or proposals received, and all of its final decisions on bids or
11 proposals received.
12 (b) The corporation shall use generally accepted hiring practices, which shall
13 be in writing and open to public inspection, for hiring any staff.

(END OF INSERT 5–16)

INSERT 6–8

14 the dollar amount that is the full premium, as determined by the corporation
15 under s. 260.15 (2) (b), for a Tier 1 health benefit plan in the county in which the
16 eligible resident resides and that has been

(END OF INSERT 6–8)

INSERT 7–6

17 4. In addition to any amounts deposited under subds. 2. and 3., the corporation
18 may deposit into the health savings account of an eligible resident who successfully

Insert 7-6 cont'd

1 follows a healthy lifestyle protocol established by the corporation under s. 260.40 (2)
2 (a), an amount determined by the corporation that is equal to the average reduction
3 in health care costs resulting from the adoption of a healthy lifestyle protocol by all
4 eligible residents who do so.

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

(END OF INSERT 7–6)

INSERT 7–10

8 Any payment to a health benefit plan under this subsection shall reflect the
9 disproportionate risk incurred by the health benefit plan.

(END OF INSERT 7–10)

INSERT 7–19

10 **(2)** TIER ASSIGNMENT AND PREMIUM DETERMINATION. (a) The corporation shall
11 rank the health benefit plans offered in each county and assign each health benefit
12 plan to one of 3 tiers, on a countywide basis, based on the health benefit plan's quality
13 and cost. The corporation shall assign to "Tier 1" health benefit plans that it
14 determines provide high quality care at a low risk–adjusted cost, assign to "Tier 2"
15 health benefit plans that it determines provide care at a higher risk–adjusted cost,
16 and assign to "Tier 3" health benefit plans that it determines provide care at the
17 highest risk–adjusted cost.

18 (b) The corporation shall determine the monthly premium amount for coverage
19 under each health benefit plan, with Tier 1 health benefit plans having the lowest
20 premiums, Tier 2 health benefit plans having higher premiums than Tier 1 health

Ins 7-9 contd

1 benefit plans, and Tier 3 health benefit plans having higher premiums than Tier 2
2 health benefit plans. The premium differences shall be based on the actual
3 differences in costs between Tier 1 and Tier 2 health benefit plans, and between Tier
4 2 and Tier 3 health benefit plans.

(END OF INSERT 7–19)

INSERT 7–24

5 An eligible resident who does not select a health benefit plan will be assigned
6 to a Tier 1 health benefit plan.

****NOTE: Do you want to specify to which plan a person is assigned if they do not select a plan? The language I have included above comes from a version of the previous draft that I was working on before receiving new, revised instructions, which did not include the tiers.

(END OF INSERT 7–24)

INSERT 8–11

7 **(2)** BENEFITS WITHOUT CERTAIN COST SHARING. Notwithstanding s. 260.25 (2) and
8 (3), deductibles, coinsurance, and copayments shall not apply to coverage of any of
9 the following:
10 (a) Emergency care, as defined by the corporation.
11 (b) Prenatal care for pregnant women.
12 (c) Well–baby care.
13 (d) Annual medical examinations for children up to 18 years of age.
14 (e) Medically indicated immunizations.
15 (f) Annual gynecological examinations for older girls and women.
16 (g) Medically indicated Papanicolaou tests and mammograms.
17 (h) Annual medical examinations for older men.

Insert 8-11 cont'd

1 (i) Medically indicated colonoscopies.

2 (j) Limited dental care, as determined by the corporation under sub. (4).

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

****NOTE: I specified that deductibles, coinsurance, and copayments do not apply. Is this what you intended?

(END OF INSERT 8–11)

INSERT 8–21

6 **(4)** DENTAL BENEFIT. Every health benefit plan shall provide coverage of dental
7 examinations and the application of coatings and sealants, as determined by the
8 corporation, for eligible residents who are at least 2 years of age but not more than
9 16 years of age.

(END OF INSERT 8–21)

INSERT 13–2

10 **260.25 Cost sharing. (1)** PREMIUMS. (a) An eligible resident with coverage
11 under a Tier 1 health benefit plan shall pay no premium in addition to the amount
12 paid by the corporation under s. 260.10 (1) to the eligible resident's health benefit
13 plan.

14 (b) An eligible resident with coverage under a Tier 2 health benefit plan or Tier
15 3 health benefit plan shall be required to pay the amount by which the full
16 risk–adjusted premium for the health benefit plan selected by the eligible resident
17 exceeds the amount paid by the corporation under s. 260.10 (1) to the eligible
18 resident's health benefit plan.

Ins 13-2 contd

1 **(2)** DEDUCTIBLES. Subject to sub. (4), in a year, an eligible resident shall pay the
2 following annual deductible amount:
3 (a) For an eligible resident who is 18 years of age or older on January 1 of that
4 year, $1,200.
5 (b) For an eligible resident who is under 18 years of age on January 1 of that
6 year, $100.
7 **(3)** COINSURANCE AND COPAYMENTS. Subject to sub. (4), in a year, after the
8 deductible under sub. (2) has been satisfied, an eligible resident shall pay all of the
9 following:
10 1. Coinsurance that is equal to at least 10 percent but not more than 20 percent
11 of medical, hospital, and generic drug costs, as determined by the corporation.
12 2. For each prescription of a brand–name drug that is on the preferred list
13 determined by the corporation under s. 260.20 (3) (a) or by the eligible resident's
14 health benefit plan under s. 260.20 (3) (b), either coinsurance of at least 10 percent
15 but not more than 20 percent or a copayment of $15, as determined by the
16 corporation.
17 3. For each prescription of a brand–name drug that is not on the preferred list
18 determined by the corporation, under s. 260.20 (3) (a) or by the eligible resident's
19 health benefit plan under s. 260.20 (3) (b), either coinsurance of at least 20 percent
20 but not more than 40 percent or a copayment of $35, as determined by the
21 corporation.

(END OF INSERT 13–2)

~~INSERT 13–3~~

Insert 13-3

1 (a) Subject to par. (c),

(END OF INSERT 13–3)

INSERT 13–4

2 (b) Subject to par. (c),

(END OF INSERT 13–4)

INSERT 13–6

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

****NOTE: Should the maximum out–of–pocket amounts include additional premium paid by persons with coverage under Tier 2 or 3 plans? As drafted, this subsection does not include premium in maximum out–of–pocket amounts.

(END OF INSERT 13–6)

INSERT 13–7

5 (a) Notwithstanding subs. (2) to (4), the corporation shall reduce the deductible,
6 coinsurance, copayment, and maximum cost–sharing amounts for low–income
7 persons, as determined by the corporation, to ensure that the cost sharing required
8 does not deter low–income eligible residents from seeking and using appropriate
9 health care services.
10 (b)

(END OF INSERT 13–7)

INSERT 13–22 10,4

****NOTE: If you don't want the coverage to be continuous, perhaps this subsection should say something along the lines of: "A preexisting condition exclusion under sub. (1) may not extend beyond the date on which the eligible resident has been covered under this chapter for a total of 18 months."

Ins 13-22 cont'd 2of4

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

10 (b) The committee shall consist of the following:

11 1. Three members designated by the Wisconsin Medical Society.

12 2. Three members designated by the Wisconsin Hospital Association.

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

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

17 5. One member designated by the Wisconsin Nurses Association.

18 6. One member designated by the Wisconsin Chiropractic Association.

19 7. One member designated by the Wisconsin Dental Association.

****NOTE: This "committee" does not fit the mold. Normally committees are short–term, advisory bodies that may be created by an entity to assist the entity with a particular issue or problem. It seems as though this committee will have a perpetual existence and advise the board indefinitely. In that case, it probably should be a council in, or attached to, a state agency. You could also simply require the corporation to establish an advisory committee on a short–term basis each time it addresses a specific issue and not specify the membership, or require the corporation to establish advisory committees composed of individuals recommended or designated by the entities you list. In any case, for the committee as drafted, do you want term lengths or are the individuals designated the permanent members?

Ins 13-22 contd 3 of 4

(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.

(d) Annually, on or before September 1, the committee shall submit to the corporation its recommendations for improving the health insurance purchasing arrangement under this chapter. The corporation shall include those recommendations 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 to adopt 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. These policies may include increasing the amount deposited in an eligible resident's health savings account as a reward for adopting a healthier lifestyle and reducing the assessment paid by an employer that institutes a work–based program 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,

Ins 13-22 contd 4 of 4

1 comprehensive, easily accessible, and easily understandable information about the
2 cost and quality of the care provided by Wisconsin health care providers and by any
3 physicians, clinics, or hospitals outside of Wisconsin that are included in a network
4 of a health benefit plan offered under the health insurance purchasing arrangement
5 under this chapter.

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

(END OF INSERT 13–22)

INSERT 14–10

11 2010, submit to the legislature under s. 13.172 (2) the plan developed under
12 sub. (1), together with its recommendations concerning the desirability of requesting

(END OF INSERT 14–10)

INSERT 14–16

13 legislature authorizes or requires the department of health and family services
14 to request the waivers specified in sub. (2) and if the

(END OF INSERT 14–16)

Kahler, Pam

From: David Riemer [driemermil@yahoo.com]

Sent: Monday, October 31, 2005 1:32 PM
To: Kahler, Pam; Shovers, Marc
Cc: Joe Leean; Lisa Ellinger
Subject: LRB-2922/P2 and LRB-2922/P2n

Attachments: 3684865640-10-31-05 Memo to LRB.doc; 2363224459-Attachment A.doc; 2632458161-Attachment B.xls

10-31-05 Memo to LRB.doc (101 ...

Attachment A.doc (38 KB)

Attachment B.xls (358 KB)

Dear Pamela & Marc--

Attached are a number of changes we would like to make in the draft as well as several questions I wanted to ask before deciding whether a change was needed.

The first attachment ("10-31-05 Memo to LRB") is a long memo to the two of you that goes through your draft, LRB-2922/P2, page by page, line by line, indicating specific changes. In most cases, I propose or suggest specific new language. (As you'll see, in about half of these situations, it's a matter of changing a single word or a number or a date.) In several instances, however--and especially on the last page--I couldn't think of the right words or don't even have a clue about wording, so I try my best to describe the concept or policy.

Please understand that my primary purpose in proposing or suggesting specific language is to clarify the request for change--not to imply that the specific new words that I spell out are 100%, exactly, totally perfect. Having worked with legislative drafters in the LRB and elsewhere for many years, I know who the pros are (you) and who the amateur is (me). You will concede, I'm sure, that sometimes I got the new language right:it's hard to replace the year "2006" with the year "2008" without making "2008" the perfect alternative. But in many cases, the specific language I propose or suggest is meant to be just that: a proposal or suggestion to be improved upon by experts.

I've also attached two other documents (Attachment A and Attachment B) that I refer to in the primary memo to you.

In your note (LRB-2922/P2n) Pam delved extensively into issues surrounding who is a "resident" for the purposes of this program. I wanted to be sure Pam knows that, at the end of the day, I'm quite satisfied with the definition you propose in s. 260.01(3)...with one exception. We need to do something to ensure that people who escape residency for Wisconsin individual income tax purposes can't retain "eligible resident" status for purposes of having & using Health Insurance Purchasing Accounts. As you'll see, I've suggested some language to ensure this result. Because this refers to the Wisconsin individual income tax, Marc may also want to look at it.

Marc, your note (in LRB-2922/P2n) dealt with the very important issue of the lag in finding that results because the program starts up on 1/1/09 (new date) & must quicklly start paying out premiums, but assessment revenue won't start flowing in until 4/09 when businesses submit their 1st quarter wage-based payments and individuals start filing their 2008 Wisconsin individual income tax returns (assuming, as I think we must, that we'll use 2008 income as the basis for the 2009 assessment). As an alternative to starting the program on 1/1/09 (as you suggest...I've moved the date up two years, but the concept is the same), I'd prefer to give the Private Health Insurance Purchasing Corporation the authority to borrow to cover its cash flow needs (or, alternatively, give DOA the authority to borrow on behalf of the Corporation, to possibly capture cheaper tax-exempt interest rates), and then allow the Corporation to retire the debt (which could be limited to this first quarter lag problem, or be more generally stated) over the course of the next five years or so (or whatever time period is reasonable for such a program). Could you prepare language that gives the Corporation such borrowing authority? And that tries to make the borrowing tax-exempt? Thanks. *

Both of you also incorporated several notes in the body of the main draft, LRB-2922/P2. I answered them as I went through that draft.

Hope all this is clear. If you have any questions, please call me at:

414-617-9148 (mobile), 414-267-6020 x223 (office), or 414-453-9674 (home). Or via E-mail to: DRiemerMil@yahoo.com

→ corp can borrow — see s. 181.0302 (7)

I'm coping this to Joe Leean, who's chairing the group that's seeking to develop consensus on this plan from business, labor, farmer, and consumer groups. I'm also copying Lisa Ellinger. If either of them have comments--or as I think of anything else--I'll be in touch.

The next meeting of the consensus-building group that Joe Leean chairs, by the way, is December 1. If there's any chance you could get us a /3 draft before that date, we'd greatly appreciate it.

Thanks so much for all your work on this project.

Best, David

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TO: Pamela J. Kahler, Senior Legislative Attorney, Legislative Reference Bureau
Marc E. Shovers, Senior Legislative Attorney, Legislative Reference Bureau

FROM: David Riemer, Project Director, Wisconsin Health Project

CC: Joe Leean, Lisa Ellinger

DATE: October 31, 2005

RE: LRB-2922/P2 and LRB-2922/P2n

Thanks so much for the draft. Following (presented on a line-by-line basis) are a number of changes we would like to make in the draft as well as several questions I wanted to ask before deciding whether a change was needed.

LRB-2922/P2

1. Page 1, line 2: Insert "Private" before "Health Insurance".

2. Page 1, line 7: Insert "Private" before "Health Insurance".

3. Page 1, line 10: Insert "Private" before "Health Insurance".

4. Page 1, line 11: Insert "No more than" before "[o]ne and one-half percent.

AND

Page 2, line 1: Insert "as determined by the board created under ch. 260," before "for the administration and collection". not bd, DOR

NOTE: Based on my initial calculations, administrative costs may be less than 1.5% of all moneys collected. Therefore, the 1.5% figure should be a maximum—a ceiling—for the percentage of revenues used for administration, rather than an absolute figure. The Board should have discretion to fix and use a smaller percent for administration if the Board determines that less is needed. I assume that, in addition to inserting the "No more than" language, is it also necessary or preferable to add some sort of "as determined by the board" language at an appropriate place in the text.

5. Page 2, line 4: Insert """PRIVATE""" before "HEALTH INSURANCE".

6. Page 2, line 13: Should "individuals" be changed to "eligible residents"? no, not a defined term for ch 20

7. Page 2, line 19: Can you explain to me what a "nonlapsible" trust fund is…as compared to other types of trust funds?

Also, along the effects of creating a trust fund, am I correct in assuming that two of the legal consequences are that the members of the board of the new Private Health Insurance

Purchasing Corporation (a) are the trustees in charge of the trust, and (b) must function as trustees vis-à-vis the corporation's decisions and operations? (FYI: I'm hoping the answer is yes in both cases, but wanted to confirm.) If so, can you tell me what Wisconsin law requires of trustees in this context? In particular, if there is a conflict or appearance of conflict between the position or self-interest of the organization that's chosen them for membership on the board vs. the position or best interest of the trust fund, the board, the corporation, or the program, what are they obliged to do or restricted from doing? Thanks.

8. Page 2, line 20: Insert" "at least" before "98.5 percent of all moneys"

AND

Page 2, line 20: Insert "as determined by the board created under ch. 260" before the final period.

NOTE: See explanation for Item #4.

9. Page 3, Line 1: Insert "Private" before "Health Insurance".

10. Page 3, between lines 9-10: Insert something like: "(b) The individual has maintained a sufficient level of weeks of residency in this state so as to be subject to this state's individual income tax requirements"

AND

Page 3, lines 10, 11, and 15, re-letter "(b)" as "(c)", "(c)" as "(d)", and "(d)" as "(e)".

NOTE: My wording may be off, but the policy (I call it the "Snowbird Policy") is crucial. Individuals who have satisfied the initial 6-months eligibility test, but who do NOT thereafter live in Wisconsin long enough during a given year to be subject to our income tax laws, should NOT quality as "eligible residents" who get Health Insurance Purchasing Accounts and the health insurance benefits that go with. Rather, snowbirds and other part-time residents who live outside of Wisconsin long enough to avoid income tax liability here should be obliged to choose: Either avoid paying our income taxes and give up the opportunity to have a Health Insurance Purchasing Account…or agree to be subject to our income tax laws, pay your fair share of taxes, and obtain or retain your Health Insurance Purchasing Account. They should not be able to have it both ways: avoid Wisconsin's income tax, but receive the benefit of Wisconsin's health insurance program. I'm sure you have much better statutory wording; I mostly wanted to emphasize the rationale and logic of the policy.

In crafting the necessary language, it is important to recognize that there are many Wisconsinites who are subject to Wisconsin's income tax laws but who don't actually pay income taxes. E.g., they may receive a refundable income tax credit like the Earned Income Tax Credit or the Homestead Credit that's large enough to offset their income tax liability, and actually get money *back* from DOR. Or, their income may be low enough to exempt them from having a tax liability. The test should therefore not be whether an individual actually pays income tax to Wisconsin's DOR, but whether they live in

Wisconsin for enough days or weeks or months to be subject to our income tax laws…whether they end up actually paying income tax to DOR or not.

11. Page 3, line 18: Insert "Private" before "Health Insurance".

12 Page 4, line 1: Insert "Private" before "Health Insurance".

13. Page 4, line 3: Change "9" to "8".

14. Page 4, line 12: Delete all of line 12.
Page 4, line13 : Re-letter "g" as "f".
Page 4, line 14: Re-letter "h" as 'g".

15. Page 4, line 18: Change "8" to "7".

16. Page 4, line 22: Re-letter "h" as "g".

17. Page 5, line 8: After "governor", delete "or" and insert ",the secretary of administration,". Also, after "legislature" and before the final period, insert: "the legislative fiscal bureau, and the legislative audit bureau".

REPLY TO QUESTION: My preference is to add nothing re: the open records law. Many of the provisions on pages 5-6 seek to ensure that the board and corporation are accountable to the public through open meetings, scrutiny by elected officials and their appointees and staff, etc. But I'm not yet persuaded that the open records law should apply to what is still meant to be a private corporation. So, for now, I'd like to remain silent on the issue…which I understand means the open records law would not specifically apply.

18. Page 5, lines 9-10: Is it necessary to include the words "of governmental bodies"? If these three words are omitted but the rest of the sentence stands, isn't the legal effect the same? If so, I'd prefer to delete: "of governmental bodies." As noted above, one of the goals is to underscore the fact that this is meant to be a private corporation.

19. Page 5, line 16: Add something along the lines of: "In entering into such contracts, the corporation shall use generally accepted bidding procedures, which it shall make public in writing, when soliciting bids or proposals, or in awarding contracts to the lowest-bidding qualifying bidder or the most qualified proposer, and shall make public all of its requests for bids or proposals, all of its analyses of bids and proposals, and all of its final decisions on bids and proposals. The corporation shall also use generally accepted hiring practices, which it shall make public in writing, when hiring any staff."

NOTE: Consistent with the need to ensure that the board adheres to the highest standards of integrity in spending the nearly $13 billion that will be deposited in the trust fund that it oversees, I believe it's important to spell out these—or some alternative version of these—basic ground-rules for contracting and hiring…while at the same time recognizing

that this is meant to be a private corporation which is intended to exercise considerable flexibility in the management and operation of its program.

20. P. 5, after line 14 (or perhaps after line 16): Insert the 4 paragraphs included in Attachment A.

NOTE: This section on the duties of the corporation seems an appropriate place to add the 4 "shall" provisions spelled out in Attachment A. But please feel to revise and improve the wording, as well as find other locations in the draft where these 4 provisions might be better placed. Thanks.

---

21. Page 6, line 5. Change '2006" to "2008".

22. Page 6, line 6: Change "2007" to "2009".

23. Page 6, after line 17:

REPLY TO QUESTION: Yes. Defining an eligible resident as an adult (i.e., 18 years or older) beginning with the first year the eligible resident is 18 years of age on January 1 is a clear, enforceable, and reasonable rule.

24. Page 6, line 18: Change "2007" to "2009".

25. Page 6, line 19: Change "2007" to "2009" AND change "$600" to "$500".

26. Page 7, after line 6: Add the following new paragraph:

> "4. If an eligible resident successfully follows a healthy lifestyle protocol, as determined by the corporation pursuant to s. ___ [insert whatever new section number you use for the board's duty to establish healthier lifestyle incentives ...see first paragraph of Attachment A], the board may deposit into the resident's health savings account an additional amount determined by the board to equal the average reduction in health care costs resulting from successful adoption of the protocol by the larger group of eligible residents."

NOTE: The proposed wording may be awkward and require substantial revision. But the policy is an important one. The policy is give the board the authority to offer an economic incentive, in the form of a bigger HSA contribution, to eligible residents who adopt a healthy lifestyle that's been shown by scientific evidence to actually lower health care costs. The new language in Attachment A, 1st paragraph, gives the board broad authority to create such incentives; and refers to increasing the HSA payment as one such possible incentive. The proposed new par. 4, above, is meant to ensure that the HSA provisions of page 6 & 7 are consistent in allowing for a larger HSA as a possible economic reward for successfully adhering to a healthy lifestyle protocol. The proposed new par. 4 also provides a specific methodology for calculating the amount of this HSA enhancement: namely, it should equal the *average* reduction in health care costs generated by adoption of the protocol by the entire group that does so.

27. Page 7, line 10: Would it make sense to add something like: "Any such payment to a health benefit plan shall reflect the disproportionate risk that the health benefit plan has incurred in a given year."

NOTE: The way the language now reads, it's implicit—but there's no requirement—that, if the corporation chooses to make disproportionate risk payments to health benefit plans, that it must do so according to a formula that actually compensates them for the *level* or *degree* of disproportionate risk they have incurred. Thus, the corporation could pay exactly the same dollar amount to a health benefit plan that's incurred a "little" disproportionate risk as it pays to a health benefit plan that's incurred a "huge" disproportionate risk. The new language I'm suggesting is meant to remedy this problem by requiring that disproportionate risk payments, if made, must be...proportional (if you'll excuse the expression).

28. Page 7, line 13: Would it be better to replace "providing" with "offering"? The bids that insurers submit are, technically, bids under which they commit to *offer* a defined health insurance benefit package to all eligible residents of a Wisconsin county for a specific price. Only when one of the eligible residents of the county "takes up" the offer during the open enrollment period by selecting a specific insurer and transferring to that insurer the premium credit portion of the eligible resident's health insurance purchasing account—and, further, only after the January 1 start-up date of coverage—does the insurer actually provide coverage pursuant to its prior bid. At the time that the corporation enters into contracts with insurers, the only thing it's technically contracting for is the insurers' offering the defined coverage at their bid prices. To clarify all this, I wonder if it would help to replace "providing" with "offering" before the word "coverage".

29. MAJOR NOTE: This discussion reminds me of an important issue I wanted to raise. The issue starts with a certain confusion about the use of the term "health benefit plan" vs. the term "insurer". For example, on p. 7, line 8, the corporation would make payments to "health benefit plans." But on p. 7, line 12, the corporation would enter into contracts with "insurers." I'm confused—and I suspect others will be as well—about the distinction that's being drawn between "health benefit plan" and "insurer."

This leads me to my major point. We are, I believe, dealing with three distinct (albeit interrelated) concepts here: (a) the health insurance benefit package being offered to eligible residents; (b) the network of doctors, hospitals, and rules that are organized to deliver the benefit package; and (c) the insurance company that submits bids, takes risk, and gets paid.

To avoid confusion and achieve greater clarity about these core concepts, I think it would help if throughout the legislation we used the following terms in the following ways (and eliminated other, overlapping terms):

- The term "health benefits" should be used to mean the entire defined package of benefits, i.e., medical insurance coverage, hospital insurance coverage, prescription drug insurance coverage, and the very limited dental insurance coverage piece we're proposing to add (to be explained later) that all "health care plans" must provide and that all "insurers" must offer;
- The term "health care plan" should be used to mean the specific network of doctors and hospitals, together with the specific rules for using the network, that an "insurer" proposes to utilize to deliver "health benefits" to eligible residents; and

•The term “insurer” should be used to describe the legal entity—the insurance company—that offers to provide the defined “health benefits” package, via one or more designated “health care plan” network of providers and associated rules, in exchange for payment (i.e., the premium credit portion of the health insurance purchasing account plus any additional out-of-pocket payment that the eligible resident must make to enroll in a Tier I or Tier III plan).

“Health benefits” (as defined by the law, including any benefits added by the corporation pursuant to its authority under the law) would be 100% the same for all “health care plans” and all “insurers.”

“Health care plans” would all provide the same “health benefits.” Different “health care plans” would differ *not* in their “health benefits” packages *but instead* in their organization. “Health care plans” would have different, competing networks of doctors and hospitals and rules (HMOs with narrower networks and tighter rules, PPOs with broader networks and broader rules, indemnity plans with unlimited networks and hardly any rules). Different “health care plans” *could* be offered by the same “insurer” (e.g., Blue Cross could simultaneously submit a bid in Milwaukee for its HMO “health care plan,” its PPO “health care plan,” and its indemnity “health care plan”), Alternately, an “insurer” might choose to offer the uniform “health benefits” package through only one “health care plan” (e.g., Group Health Cooperative in Madison may only want to offer an HMO “health care plan”).

“Insurers” would be the legal entities—regulated by OCI, bearing risk, and getting paid for all the eligible residents they’re at risk for providing “health benefits” to through one or more the “health care plans” they’ve entered into the market.

No taxonomy is perfect; and perhaps this one adds some confusion. But in the end I do think it’s useful to distinguish between (a) the benefit package itself, (b) the delivery mechanism of networks (some tight, some loose) of doctors, hospitals, and rules of use, and (c) insurance companies. And one virtue of the three terms proposed above is that these are the ones that I’ve been using for the last year in describing the overall progam.

✓30. ANOTHER MAJOR NOTE:

Page 7, after either line 19 or line 24. Something needs to be added to explain how the “tiering” process would work. It’s important that the legislation explicitly provide that: (a) the corporation would be required, on a county-by-county basis, to place the competing insurers’ plans into three “tiers” based on risk-adjusted cost and quality measures; (b) the corporation must designate as “Tier I” plans that provide health insurance at the lowest risk-adjusted cost and have the highest quality measures; (c) the corporation must designate as “Tier II” and “Tier III” those plans have higher risk-adjusted costs; (d) eligible residents shall be free to select any plan from any “tier”; (e) the premium credit (whose dollar value is risk-adjusted, as explained on p. 6, lines 6-9) shall pay for the entire premium of an “Tier I” plan; and (f) if an eligible resident chooses to enroll in a “Tier II” or “Tier III” plan, the eligible resident would be responsible for paying out-of-pocket for the extra cost, as determined by the corporation, of the “Tier II” or “Tier III” plan.

I apologize if I missed this omission in the prior draft. But it is such an essential feature of the entire program, and there are so many risks if it’s left entirely to the corporation to set up a “tiering” system without statutory guidance, that it must be explicitly included in the text of the statute.

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32. Page 7, line 20: Replace “2006” with “2008”.

33. Page 7, lines 21 and 23: Delete “in November”.

NOTE: Several commentators have questioned whether over 4 million Wisconsin residents can enroll during only a single month in the health care plans of their choice. They have suggested a rolling enrollment period, lasting 6 months or more. To allow the corporation to make the decision about when the open enrollment period should be—November, a different single month, or a longer period of several months—the words “in November” must be deleted.

34. Page 8, line 2: Change “2007” to “2009”.

34. Page 8, line 2: After coverage, insert a comma; and delete “and”.
Page 8, line 3: After “prescription drug coverage”, insert a comma as well as the words “and limited dental care coverage” before the final period.

35. Page 8, line 6: After “procedures”, insert “for which there is evidence that exemption from cost sharing is likely to reduce health care costs or avoid health risks” before the comma.

NOTE: The new wording may be awkward and require improvement. But the idea is to require the corporation, in determining which preventive services or procedures should be exempt from cost sharing, to look to the medical and economic *evidence* as to *which* preventive services or procedures—when exempted from cost sharing—will result in a reduction in health care costs or the avoidance of health risks. In other words, the corporation shouldn't be exempting preventive services from cost sharing based on hunches or anecdotes. Rather, evidence of some sort should guide its decisions.

36. Page 8, line 7: After “including” insert “pre-natal care for pregnant women,”.

37. Page 8, line 10: Delete “and”.
Page 8, line 11: After “colonoscopies”, insert a comma as well as the words “and the limited dental care coverage defined in par. 4” before the final period.

38. Page 8, between lines 21 and 22, insert a new paragraph as follows:

“(4) DENTAL BENEFIT. Coverage shall include dental check-ups and the application of coatings and sealants, as determined by the corporation, for children no younger than 2 years of age and no older than 16 years of age, as determined by the corporation.”

39. Page 9, line 1: Replace “(3)” with “(4)”.

40. Page 9, line 16: Replace “Medicare” with “Social Security”.

NOTE: See note for item #44.

41. Page 10, lines 6 through 10: Replace this formula with the following new formula:

"1. Five percent of the first $50,000 of Social Security wages.

"2. For each increment of $1,000 in additional Social Security wages in excess of $50,000 of Social Security wages, all Social Security wages shall be assessed at five percent plus the product of the number of such increments times two hundredths of one percent.

"3. Notwithstanding subpar. 2, once total Social Security wages reach $499,000, all Social Security wages shall be assessed at 14 percent."

NOTE: See note for item #44.

42. Page 10, line 19: Replace "(b)" with "(c)".

43. Page 10, line 21, lines 21-25: Replace this formula with the following new formula:

"1. Three percent of the first $50,000 of Social Security wages.

"2. For each increment of $1,000 in additional Social Security wages in excess of $50,000 of Social Security wages, all Social Security wages shall be assessed at three percent plus the product of the number of such increments times two hundredths of one percent.

"3. Notwithstanding subpar. 2, once total Social Security wages reach $499,000, all Social Security wages shall be assessed at 12 percent."

NOTE: See note for item #44.

44. Page 10, after line 25: Insert the following new paragraph:

"(b) Except as provided in par. (c), an employer shall deduct from the wages of each of its employees an amount equal to two percent of the social security wages of each employee, and shall remit the amount deducted to the department at the same time that it pays the amount described in par. (a), as provided in sub. (4)."

MAJOR NOTE: As you can see from items #40 through 44, we have decided to make a major change in the assessment formula.

Please see Attachment B, columns A, B, L, & M, to see the details of the new formula. (You can ignore the other columns; they depict options we decided not to go with.)

To avoid confusion, let me try to walk you through in "non-legalese" how the new formula works:

- The assessment would now be based on Social Security wages rather than Medicare wages.
- Businesses would pay a sliding-scale assessment as follows:
  - --The first $50,000 would be assessed at 3%.

--Then, for each additional $1,000 of wages, the assessment rate would increase by 0.02%--until wages reach $499,000, at which point the assessment rate would be capped at 12%.

--It is important to understand that these rates apply to *all* wages—both the base and the increments. Thus, an employer aggregate Social Security wages of $45,000 would pay 3% x $45,000 = $1,350. But an employer with aggregate Social Security wages of $50,500 would pay 3.02% x $50,500 = $1,525.10.

• Employees would pay a flat 2% of social security wages, which their employers would deduct from their paychecks and remit to DOR.

• Self-employed individuals would pay the *combined* employer and employee rates.

• Individuals with no or low Wisconsin earnings, but "high" federal AGI, would not be affected. (That is, those covered by the provision on p. 10, lines 11-15.)

One issue I have not fully addressed in Attachment B is precisely where the boundaries falls between lower wage assessment rate and a higher wage assessment rates. In Attachment B, I have used rough $1,000 wage increments to illustrate, approximately, how the sliding scale works. I assume, however, that in drafting this you'll need to be far more precise—getting down to the single dollar level, and putting in a lot of "at least" and "no greater than" wording, among other things. For example, I assume you'll need to draft the statutory language so that it specifies with complete clarity that: the 3% rate applies to all wages of $50,000 or less; the 3.02% rate applies to all wages of at least $50,001 but no greater than $51,000; the 3.04% rate applies to all wages of at least $51,001 but no greater than $52,000; etc. If in doing this you discover that the point at which the 12% maximum rate applies is not $499,000 but $499,001 (or even $500,001), please correct accordingly. Thanks.

QUESTION: One question I wanted to ask, which relates to both the original assessment formula and this new formula, is whether we should say something about how the *quarterly* nature of the business assessment process influences the way DOR would collect the assessments.

This issue doesn't apply to the new, flat 2% employee assessment, since a flat percentage wage assessment is exactly the same whether it kicks in quarterly or annually. Nor does it apply to the self-employed individual assessment, since this particular assessment is linked to federal form SE which is only filed on an annual basis. But businesses face (under both the original and the new formula) a sliding scale assessment, and they file federal form 941 quarterly.

One option would be to require businesses to pay quarterly based on wages that are exactly 25% of the wage amounts we now propose. I.e., we could say that, every quarter, a business pays 3% of the first $12,500 of Social Security wages *for that quarter.* The maximum 12% would kick in at $124,750 ($499,000 x 25%) of Social Security wages *for that quarter*. This solves the problem of telling smaller employers, who don't know until the end of the 4th quarter what their annual wages will be and thus don't know what their annual assessment rate should be, exactly what final rate to apply and what final payment to make for each each quarter. It eliminates the need to treat such quarterly

rates and quarterly payments as tentative—subject to upward (or downward) adjustment when the employers' final year-end wages become known. On the other hand, this option creates the potential unfairness that employers with the same *annual* wages will pay different assessment rates and amounts because their *quarterly* wages and thus quarterly assessment rates happened to differ. In short, this option maximizes simplicity but risk inequity.

The other option is of course to require businesses to use their quarterly assessment rates as reasonable proxies—as sensible guides--for what their final annual assessment rates and final annual payment will be, but to require them as part of their final 4th quarter payments to adjust (in either direction) their annual assessment rates and payments to reflect their actual annual wages. This option creates complexity and paperwork, but maximizes equity (or at least, for some, the feeling of equity).

As you can tell from my comments, I'm inclined to go with the first option: requiring businesses to pay quarterly, applying the new assessment rates per quarter to 25% of the (now annual) social security wage amounts we're now proposing. This option would greatly reduce complexity and thus confusion and paperwork. Only for smaller employers (with annual wages below $124,750 per quarter) would it make any difference in the outcome. For the smaller employers for whom it might alter the final outcome, it doesn't have any upwards or downward bias on the total amount paid. I doubt, moreover, that the generally modest differences with the other (annual adjustment) option will create any significant perceptions of inequity in the small employer community or elsewhere.

So I would like to go down this path, but wanted to ask your opinion (among others) before finalizing the decision. What do you think?

45. Page 11, line 1: Re-letter "(b)" as "(c)", and change "2007" to "2009".

46. Page 11, line 2: After union, insert "prior to Janujary 1, 2009," .

NOTE: Perhaps this is overkill, but I wanted to be absolutely sure that only collective bargaining agreements entered into prior to 1/1/09 fall within this special exemption.

47. Page 3, lines 3 and 4: Replace "medicare" with "Social Security".

48. Page 11, line 14 : Insert "at least" before "98.5 percent".

Page 11, line 16: Insert "no more than" before "1.5 percent".

NOTE: This change is required to be consistent with Items #4 and 8. See explanation in Note to Item #4.

49. Page 11, line 18, through page 13, line 22.

Wouldn't it make sense to move s. 260.25 (re: cost-sharing) and s. 260.30 (re: preexisting condition exclusion) to a position in the text that immediately

follows s. 260.20 (re: benefits), since both the cost-sharing and preexisting condition sections relate to benefits and function as limitations on the benefits provided by insurance? By the same logic, wouldn't it make sense to move s. 260.22 (re: assessments) to a place in the text that then comes after a series of sections on benefits, cost-sharing, and preexisting conditions?

In other words, I'm proposing that, in order to make the flow of the statute more logical and easier to follow, s. 260.25 should be renumbered as s. 260.22, s. 260.30 be renumbered as s. 260.25, and s. 260.22 be renumbered as s.260.30.

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50. Page 12, lines 1 through 11: Replace current text with the following:

"(b) After the deductible required by sub. (a) has been satisfied, co-insurance equal to at least 10% but not to exceed 20% of medical, hospital, and generic drug costs, as determined by the corporation.

"(c) After the deductible required by sub. (a) has been satisfied, and in addition to the co-insurance required by sub. (b), for each prescription of a brand-name drug that is on the preferred list determined by the corporation under sec. 260.20(3)(a) or a health care plan under s. 260.20(3)(b), either an additional co-insurance rate of at least 10% but not to exceed 20% of the cost of the prescription or a co-payment of $15, as determined by the corporation;

"(d) After the deductible required by sub. (a) has been satisfied, and in addition to the co-insurance required by sub. (b), for each prescription of a brand-name drug that is not on the preferred list determined by the corporation under sec. 260.20(3)(a) or a health care plan under s. 260.20(3)(b), either an additional co-insurance rate of at least 20% but not to exceed 40% of the cost of the prescription or a co-payment of $35, as determined by the corporation."

NOTE: See Note to Item #52.

51. Page 12, line 16, through Page 13, line 2: Replace current text with the following:

"(b) After the deductible required by sub. (a) has been satisfied, co-insurance equal to at least 10% but not to exceed 20% of medical, hospital, and generic drug costs, as determined by the corporation.

"(c) After the deductible required by sub. (a) has been satisfied, and in addition to the co-insurance required by sub. (b), for each prescription of a brand-name drug that is on the preferred list determined by the corporation under sec. 260.20(3)(a) or a health care plan under s. 260.20(3)(b), either an additional co-insurance rate of at least 10% but not to exceed 20% of the cost of the prescription or a co-payment of $15, as determined by the corporation;

"(d) After the deductible required by sub. (a) has been satisfied, and in addition to the co-insurance required by sub. (b), for each prescription of a brand-name drug that is not on the preferred list determined by the corporation under sec. 260.20(3)(a) or a health care plan under s. 260.20(3)(b), either an

additional co-insurance rate of at least 20% but not to exceed 40% of the cost of the prescription or a co-payment of $35, as determined by the corporation."

NOTE: See Note to Item #52.

52. Page 13, line 5: Replace "$1,000" with "$500".

Page 13, line 6. After the period add the following new sentence:

"A family consisting of two or more eligible residents may not be required to pay more than $3,000 per year in total cost-sharing."

Page 13, line 7: Delete "FOR INFLATION" and insert after the period the following new sentence: "Notwithstanding subs. (1) to (3), the corporation shall reduce the deductible, co-insurance, co-payment, and maximum amounts for low-income persons, as determined by the corporation, so as to ensure that the cost sharing they are subject to does not deter them from seeking and using appropriate health care services."

Page 13, line 8: Replace "2008" with "2010".

NOTE: The changes in Items # 50, #51, and #52 are part of a consensus package we're working on to simplify the cost-sharing structure, and make the cost-sharing levels more reasonable for a typical Wisconsin family, with significantly increasing the cost of the program.

REPLY TO QUESTION on Page 13, line 12: Yes. Adjustments in cost-sharing should apply to *all* eligible residents, not just those with (or without) HSAs.

53. Page 13, line 16: Replace "12-month" with "18-month".

Page 13, line 21: Replace "36 months" with "18 months"

Page 13, line 22: Delete "continuously".

NOTE: The goal is to have the 18-month (as revised) limit on coverage of pre-existing conditions—which amounts to a 24-month limit after the person has moved to Wisconsin because of the 6-month residency requirement prior to becoming an eligible resident--to be 18 months of *total* coverage (as opposed to continuous coverage). Total coverage may itself be difficult to define and measure; but total continuous coverage seems even harder to define and measure.

54. Page 14, line 5: Change "(c)" to "(d)".

NOTE: See #10 re: addition of an additional eligibility requirement.

REPLY TO QUESTION: I believe that the s. 260.01 definition of "eligible resident" precludes *all* persons 65 or more, whether eligible for MA benefits or not, from becoming eligible residents under the Wisconsin Health Plan.

The way you've drafted it, I also believe that the s. 260.01 definition of eligible residents also excludes persons eligible for MA based on disability from becoming eligible residents under the Wisconsin Health Plan. On page 3, lines 15-17, unless I'm missing something, you presumptively exclude *all* MA and BadgerCare *eligibles*—not just enrollees, but all those *eligible* for MA and BadgerCare—from qualifying as "eligible residents." Then, in the "unless" clause of that part of the s. 260.02 definition on page 3, line 15, in combination with s. 260.60, you carve out from this presumptive exclusion those low-income families who fall in the *non-elderly, non-disabled* low-income family category of MA as well as who fall into BadgerCare IF the waiver requesting their inclusion as "eligible residents" is granted and in effect. I think you've done a masterful job.

55. Page 14, line 10: Replace "2006" with "2010" .

AND

Page 14, lines 10: Replace "request" with the following: "submit the plan developed under sub. (1) to the legislature, together with its recommendations to the legislature concerning the desirability of requesting"

56. Page 14, line 16: Delete "waivers requested under sub.(2)" and substitute the following: "the legislatures authorizes the department of health and family services to request waivers from the secretary of the federal department of health and human services and if the such waivers"

57. Page 15, line 9: Replace "2006" with "2008".

58. Page 16, line 16: Replace "2006" with "2008".

59. Page 16, lines 9, 14, and 18: Replace "2007" with "2009".

Additional Provisions

60. Please add a strong "separability" clause that provides that if any provision of the law is found to violate the U.S. Constitution, a federal statute (e.g., ERISA), or an applicable federal administrative rule, or is found to violate the Wisconsin Constitution, the offending provision *alone* shall be unenforceable, but the rest of the law shall remain in full force and effect. see s. 990.001 (11)

61. Repeal the Milwaukee County GAMP program, and the state's subsidy for that program, effective 1/1/09. (Date?)

wait until act passes

*62. Repeal HIRSP (Health Insurance Risk Sharing Program), and the taxes and other financing mechanisms used to support it, effective 1/1/09. (later?)

63. Repeal the Wisconsin personal property tax effective 12/31/09, and require that beginning 1/1/10 each local jurisdictions shall receive a payment in lieu of this tax that equals the personal property tax revenue it collected in 2009.

64. Reduce the Wisconsin corporate income tax rate from its current level by 30% effective 1/1/10; by 40% effective 1/1/11; by 50% effective 1/1/12; by 60% effective 1/1/13; by 60% effective 1/1/14; by 70% effective 1/1/15; by 80% effective 1/1/16; by 90% effective 1/1/17 and by 100% effective 1/1/18.

65. Create a new refundable Earned Income Tax Credit for all workers, effective 1/1/09, as follows: on the Wisconsin individual income tax, all filers may claim a refundable credit of 2% of all earnings not to exceed $300 per year (i.e., the lower of 2% of earnings or $300), but beginning with earnings in excess of $20,000 the credit shall be reduced by $20 for each additional $1,000 of earnings (thus phasing out completely by $35,000).

In addition, increase the current Earned Income Tax credit percentages as follows: for a filer with one dependent children, increase the percentage of the federal EITC that the filer can claim as a state Earned Income Tax Credit from 4% to 6%; for a filer with two dependent children, increase the percentage of the federal EITC that the filer can claim as a state Earned Income Tax Credit from 14% to 16%; and for a filer with three or more dependent children, increase the percentage of the federal EITC that the filer can claim as a state Earned Income Tax Credit from 43% to 45%.

NOTE: I may come back to you with modifications in these EITC provisions.

But see 11/10/05 e-mail for most recent instructions

Health Care Advisory Committee

A Health Care Advisory Committee shall be created to advise the Board on all matters related to the promotion of healthier lifestyles; the promotion of health care quality; increasing the transparency of health care cost and quality information; preventive care; disease management; appropriate utilization of primary care, medical specialists, prescription drugs, and hospital emergency rooms; confidentiality of medical information; appropriate use of technology; benefit design; availability of physicians, hospitals, and other providers; and reduction of health care costs. The Health Care Advisory Committee shall consist of eleven members, three of whom shall be appointed by the State Medical Society; three of whom shall be appointed by the Wisconsin Hospital Association; one of whom shall be appointed by the Dean of the University of Wisconsin-Madison School of Medicine; one of whom shall be appointed by the President of the Medical College of Wisconsin; one of whom shall be appointed by the Wisconsin Nurses Association; one of whom shall be appointed by the Wisconsin Chiropractic Association; and one of whom shall be appointed by the Wisconsin Dental Association The chair of the Health Care Advisory Committee shall serve as a non-voting member of the Board; shall at every meeting of the Board communicate to the Board the advice and recommendation of the Committee; and shall communicate to the Committee the questions on which the Board is seeking the Committee's advice or recommendations. Every year, the Committee shall submit to the Board its recommendations for improving the Wisconsin Health Plan. The annual report of the Board to the Legislature shall include these recommendations.

Attachment A

Healthier Lifestyle (Behavior/Wellness) Incentives:

The Board, in consultation with the Health Care Advisory Committee and other experts on creating effective incentives for individuals and employers to adopt healthier lifestyles, shall adopt evidence-based policies that create incentives for (1) individuals to adopt healthier lifestyles and (2) employers to put in place proven work-based programs that have been shown to improve the health status of employees and their families. Such policies may include: (a) increasing the dollar amount credited to adults' HSAs as a reward for adopting healthier lifestyles and (b) reducing the assessment paid by employers that put in place proven work-based programs that have been shown to improve the health status of employees and their families.

Transparency of Health Care Cost and Quality Information:

The Board, 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, shall adopt policies that provide Wisconsin residents with current, comprehensive, easily accessible, and easy-to-understand information about the cost and quality of the care provided by all Wisconsin health care providers (and any non-Wisconsin doctors, clinics, or hospitals specifically included by health care plans in their networks).

Promotion of Health Care Quality

The Board, in consultation with the Health Care Advisory Committee, the Wisconsin Health Information Organization, the Wisconsin Collaborative for Health Care Quality, and other medical and non-medical experts on health care quality, shall promote evidence-based improvements in the quality of health care delivery in Wisconsin.

TAX MES

Kahler, Pam

From: David Riemer [driemermil@yahoo.com]
Sent: Thursday, November 10, 2005 12:53 PM
To: Kahler, Pam; Shovers, Marc
Cc: Joe Leean; Lisa Ellinger
Subject: Revision in EITC Formula

Pam & Marc--

In the memo I sent you on October 31, 2005, Item #65 requested inclusion of an additional set of provisions relating to the state's Earned Income Tax Credit.

I've looked more carfully at how to do this so as to reduce this new feature's complexity and spend approximately $110-$120 million in 2009. I would now request that (instead of the changes originally sought) you include the following provisions in the next draft:

A. For filers with no qualifying children, create a new refundable Wisconsin Earned Income Tax Credit (EITC) equal to the federal EITC that the filer has claimed.

B. For filers with one qualifying child, increase the Wisconsin EITC from 4% to 25% of the federal EITC.

C. For filers with two qualifying children, increase the Wisconsin EITC from 14% to 40% of the federal EITC.

D. For filers with three or more qualifying children, increase the Wisconsin EITC from 43% to 65% of the federal EITC.

E. The new state EITC (i.e., A) and the increases in the state EITC (i.e., B, D, and D) would be effective with respect to state individual income tax returns filed for calendar year 2008, i.e., could first be claimed in 2009.

FYI: I roughly estimate that the new state EITC (i.e., A) and the increases in the state EITC (i.e., B, D, and D) will roughly add up to $115 million in 2009.

Please let me know if you have any questions.
Thanks.

David

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TAX

Kahler, Pam

From: David Riemer [driemermil@yahoo.com]
Sent: Thursday, November 10, 2005 1:44 PM
To: Kahler, Pam; Shovers, Marc
Cc: Joe Leean; Lisa Ellinger
Subject: Further Revisions

Pam & Marc--
I made some technical mistakes towards the end of my Oct. 31, 2005, memo to you that I wanted to correct.

Item # 63 should read: Repeal the Wisconsin personal property tax effective 1/1/09, and require that beginning 1/1/09 eachlocal jurisdiction shall receive a payment in lieu of this tax that equals the personal property tax revenue it received in 2008.

Item # 64 should read: Reduce the Wisconsin corporate income tax from its current level by 30% effective 1/1/09; by 40% effective 1/1/10; by 50% effective 1/1/11; by 60% effective 1/1/12; by 70% effective 1/1/13; by 80% effective 1/1/14;by 90% effective 1/1/15; and by 100% effective 1/1/16.

Sorry for the original mistakes. Thanks for making these corrections.
And thanks for your understanding.

David

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Kahler, Pam

From: David Riemer [driemermil@yahoo.com]
Sent: Thursday, November 03, 2005 3:16 PM
To: Kahler, Pam; Shovers, Marc
Cc: Joe Leean; Lisa Ellinger
Subject: One Further Change

MES
HSA TAX

Pam & Marc--

There's one additional change in LRB-2922/P2 that I forgot to mention in my prior message.

Please add: Amendments to Wisconsin tax law so that the favorable treatment for Health Savings Accounts (HSAs) now provided by *federal* tax law are also provided by *state* tax law.

I don't know the details of this, but assume it means that (1) the contributions by the Private Health Insurance Purchasing Corporation to an "eligible resident's" Health Insurance Purchasing Account's HSA account would not be treated as taxable income for Wisconsin individual income tax purpose, and (2) any increase in the value of the HSA account would also be exempt fom taxation for Wisconsin income tax purpose. Is that correct?

Essentially, what I think we're looking for here is to include in LRB-2922/P2 the HSA bill language that you've already drafted, that the Legislature has passed several times, and that the Governor has vetoed each time with the Legislature failing to override.

Hope this is clear. Let me know if you have any questions. Thanks.

(2) INT All?

David

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1				**Current**		**......................Percent-of-Payroll Assessment Options...........................**										
2	**If Annual Wages:**			**Average**												
3						**If: 8% -12.5%**			**If: 1% -10%**			**If: 3% -12%**			**If: 4% -12.75%**	
4	**At Least:**	**Less Than:**		**16%**		**%**	**$$$**		**%**	**$$$**		**%**	**$$$**		**%**	**$$$**
5																
6																
31	$24,000	$25,000		$4,000		8.00%	$2,000		1.00%	$250		3.00%	$750		4.00%	$1,000
56	$49,000	$50,000		$8,000		8.00%	$4,000		1.00%	$500		3.00%	$1,500		4.00%	$2,000
81	$74,000	$75,000		$12,000		8.00%	$6,000		1.50%	$1,125		3.50%	$2,625		4.50%	$3,375
106	$99,000	$100,000		$16,000		8.00%	$8,000		2.00%	$2,000		4.00%	$4,000		5.00%	$5,000
131	$124,000	$125,000		$20,000		8.20%	$10,250		2.50%	$3,125		4.50%	$5,625		5.50%	$6,875
156	$149,000	$150,000		$24,000		8.33%	$12,500		3.00%	$4,500		5.00%	$7,500		6.00%	$9,000
181	$174,000	$175,000		$28,000		8.43%	$14,750		3.50%	$6,125		5.50%	$9,625		6.50%	$11,375
206	$199,000	$200,000		$32,000		8.50%	$17,000		4.00%	$8,000		6.00%	$12,000		7.00%	$14,000
231	$224,000	$225,000		$36,000		8.67%	$19,500		4.50%	$10,125		6.50%	$14,625		7.50%	$16,875
256	$249,000	$250,000		$40,000		8.80%	$22,000		5.00%	$12,500		7.00%	$17,500		8.00%	$20,000
281	$274,000	$275,000		$44,000		8.91%	$24,500		5.50%	$15,125		7.50%	$20,625		8.50%	$23,375
306	$299,000	$300,000		$48,000		9.00%	$27,000		6.00%	$18,000		8.00%	$24,000		9.00%	$27,000
331	$324,000	$325,000		$52,000		9.15%	$29,750		6.50%	$21,125		8.50%	$27,625		9.50%	$30,875
356	$349,000	$350,000		$56,000		9.29%	$32,500		7.00%	$24,500		9.00%	$31,500		10.00%	$35,000
381	$374,000	$375,000		$60,000		9.40%	$35,250		7.50%	$28,125		9.50%	$35,625		10.50%	$39,375
406	$399,000	$400,000		$64,000		9.50%	$38,000		8.00%	$32,000		10.00%	$40,000		11.00%	$44,000
431	$424,000	$425,000		$68,000		9.68%	$41,125		8.50%	$36,125		10.50%	$44,625		11.50%	$48,875
456	$449,000	$450,000		$72,000		9.83%	$44,250		9.00%	$40,500		11.00%	$49,500		12.00%	$54,000
531	$524,000	$525,000		$84,000		10.00%	$53,625		10.00%	$52,500		12.00%	$63,000		12.75%	$66,938
533																

534 Notes:

535 (1) Assumes that, for the 8%-12.5% assessment formula, the 1st $100,000 of wages will be assessed at 8%;
536 the 2nd $100,000 wage increment will be assessed at 9%; the 3rd $100,000 iwage increment will be assed at 10%;
537 the 4th $100,000 wage increment will be assessed at 11%; and all remaining wages will be assessed at 12.5%.

538 (2) Assumes that, for other assessment formulas, the lowest percentage will be applied to the first $50,000 of wages;
539 and that for each additional $1,000 of wages, an additional 2/100ths of a percent will be added to the rate of
540 assessment, AND the new rate will apply to ALL wages (i.e., base AND increment), until the maximum rate is reached.

541

Kahler, Pam

From: Kreye, Joseph
Sent: Thursday, November 10, 2005 2:31 PM
To: 'David Riemer '
Cc: Kahler, Pam; Shovers, Marc
Subject: LRB-2922

David,

I am working with Pam and Marc on this draft. I draft in the areas of corporate income and franchise taxes and property taxes. Your memo dated October 31, 2005, requests the repeal of personal property taxes and an extended phase-out of corporate income and franchise taxes. Please note that both of these requests involve some complicated drafting issues which may delay the completion of this bill. I will send a separate e-mail related to any questions I have regarding the phase-out of corporate income and franchise taxes. This e-mail concerns issues related to the repeal of personal property taxes that I want to bring to your attention before I start drafting:

1. The assessment of personal property is very different from the assessment of real property because a) personal property is subject to depreciation and obsolescence and b) personal property is being added to and removed from the tax base on a regular basis. This creates some significant problems with regard to replacing the tax on personal property with a payment-in-lieu of taxes (not to mention the uniformity clause issues specified in item 2).

If a payment-in-lieu of taxes is based on the amount of the 2008 tax paid by the taxpayer, how do you treat a business that did not exist in the taxation district prior to 2009 and, therefore, did not pay 2008 taxes? If a business has less personal property in 2009 than in 2008, or if the value of the property is less, would its payment-in-lieu of taxes be adjusted accordingly? Conversely, if the business acquires new property in 2009, would the payment be adjusted to reflect that addition? How would the value of such property be determined once the mechanism for determining the value of personal property is repealed? From a practical (and political) standpoint, a business isn't going to prefer a payment-in-lieu of taxes mechanism over a personal property tax if the payment-in-lieu of taxes mechanism doesn't address the problems raised by basing a system on a fixed amount of taxes paid in a prior year. In addition, as discussed below, a payment mechanism that does not address the issues mentioned in this paragraph may be constitutionally infirm. Finally, if we need to create a payment-in-lieu taxes mechanism to deal with all the complexities of a personal property tax system, then why not leave the personal property tax system in place?

2. Replacing the tax on personal property with a payment-in-lieu of taxes mechanism may violate the uniformity requirement under Article VIII, section 1 of the Wisconsin Constitution (the uniformity clause) because it, in essence, creates a prohibited partial exemption whereby some taxpayers who are "exempt" from the imposition of property taxes must make payment-in-lieu of taxes while others who are exempt may enjoy their exemptions without making such payments. For example, the Attorney General has opined that a legislative proposal that would authorize municipalities to impose "municipal service fees" on certain categories of property that are exempt from local general property taxes violates the uniformity clause. See, 79 Op. Atty. Gen. Wis. 64 (April 4, 1990). The following is from that opinion:

"It seems obvious that the municipal service fee is deemed by the Legislature to be a substitute for the general property tax for certain classes of now tax-exempt property. With respect to the classes of services mentioned in the bill, e.g., police and fire protection and garbage collection and disposal, owners of taxable property pay for these municipal services through the property tax. The effect of the municipal service fee proposal would be that certain owners of tax-exempt property who receive the same municipal services as taxable property owners, would pay for some of those in the form of a 'fee' instead of a tax. Owners of tax-exempt property subject to the municipal service fee would, then, in effect enjoy only a partial exemption, a violation of the Uniformity Clause."

Although I am not sure how a court would rule on your suggested provisions, I believe that you should at least be aware of any possible challenge to those provisions. In short, you don't want to create a "disguised property tax": a mechanism that seems to be a "tax" on personal property without provisions ensuring its uniform application. Obviously, I can repeal the personal property tax as suggested without the payment-in-lieu of taxes provision, but I don't know if that is consistent with your intent. Please advise of how you would like me to proceed.

3. As a practical, procedural matter, adding the repeal of the personal property tax (and the phase-out of corporate income and franchise taxes) to the bill will cause the bill to be referred to the Joint Survey Committee on Tax Exemptions which, as of now, refuses to meet, thereby holding up or killing every bill that is referred to the committee.

Please contact me if you have any questions.

Joe

Joseph T. Kreye
Senior Legislative Attorney
Legislative Reference Bureau
(608) 266-2263

Kahler, Pam

From: Kreye, Joseph
Sent: Friday, November 11, 2005 9:49 AM
To: 'David Riemer'
Cc: Shovers, Marc; Kahler, Pam
Subject: RE: FW: LRB-2922

David,

Thanks for the clarification. I believe that the state payment resolves the issues I discussed related to payments-in-lieu of taxes paid by a taxpayer to a local unit of government.

With regard to the committee referrals, the bill will be referred to some other committee(s). However, regardless of what any other committee does with the bill, if the bill has to go to the Joint Survey Committee on Tax Exemptions, under s. 13.52 (6), the bill cannot be considered by either house of the legislature until the committee submits its report on the bill. So although the bill may get a hearing in some other committee, it will not be scheduled for a vote in either house until it is reported out of the joint survey committee, which, as I mentioned previously, refuses to meet. One way around this is to draft the bill without the "exemptions" and then introduce a substitute amendment for whatever other committee considers the bill that would include the exemptions. Anyway...

In the meantime, I can begin drafting the personal property tax and corporate income and franchise tax provisions. Thanks again for the clarification.

Joe

Joseph T. Kreye
Senior Legislative Attorney
Legislative Reference Bureau
(608) 266-2263

-----Original Message-----
From: David Riemer [mailto:driemermil@yahoo.com]
Sent: Thursday, November 10, 2005 5:49 PM
To: Kreye, Joseph
Cc: Shovers, Marc; Kahler, Pam
Subject: Re: FW: LRB-2922

Joseph--
Thanks for your E-mail. I've also sent to Pam & Marc--and will shortly send to you--two follow up E-mails that I've sent them that pertain to your area of responsibility. One of these follow-up E-mails revises several details in the request to eliminate the personal property tax and phase out the corporate income tax.

On quickly reviewing your questions, below, however, I wanted to be sure from the get-go that we were on the same page. The drafting request re: repeal of the personal property tax (in the original request and the revised request I sent out today & will soon send to you) calls for (A) eliminating the tax altogether, and (B) requiring the state to send annual payments to each local government that formerly received revenue from the tax in an amount equal to--and frozen at the level of--the amount the local government (i.e., municipality, county, school board, etc.) received in 2008.

Perhaps my use of the concept of "payment in lieu of tax" is the source of the confusion. Usually, as you indicate, this means that a taxpayer--instead of making a tax payment to a government--makes a "payment in lieu of taxes" to the same government. But I use the phrase and concept in quite a different way. I'm talking about the state itself (not businesses within the jurisdiction of a local government) sending annual payments to local governments that replacs the tax revenue that those government used to collect from their local businesses.

This clarification, it seems to me, answers most of your questions. E.g., you ask: "How do you treat a business that did not exist in the taxation district prior to

2009 and, therefore, did not pay 2008 taxes?" The answer is: Our proposal doesn't "treat" such business, or "treat" any other business, in any particular way at all...other than to say that all such businesses no longer pay the personal property tax after the effective date of its repeal. Another example: you ask: "If a business has less personal property in 2009 than in 2008, or if the value of the property is less, would its payment-in-lieu of taxes be adjusted accordingly?" The answer is: The business doesn't make any payment-in-lieu-of taxes, and therefore there's nothing to adjust?

In short, I believe that (because my explanation of the proposal in the Oct. 31 memo was inadequate) you have been interpreting the proposal differently than I intended it. My sense is that most if not all of your qeustions are the result of this misunderstanding, and that once the misunderstanding is cleared up the questions largely or entirely disappear. Do you agree?

If so--and then starting anew with the proposal as intended--do any of your questions still apply? Can you identify which ones?

Regarding your last point about the Joint Committee on Taxation, would the rules of the Legislature require that the bill--with these tax provisions included--be referred ONLY to the Joint Committee on Taxation? Or would it be referred jointly (if you'll excuse the expression) to the legislative committees with jurisdiction over Medicaid/BadgerCare, health insurance, and/or health policy? We certainly want the bill to have a hearing...indeed, multiple hearings. But it may not be necessary to have EVERY committee with jurisdiction hold a hearing, as long as one or more committees with jurisdiction gets the bill & is willing to hold hearings.

Thanks.

David

--- "Kreye, Joseph" <Joseph.Kreye@legis.state.wi.us> wrote:

\>
\> > David,
\> >
\> > I am working with Pam and Marc on this draft. I draft in the areas
\> > of corporate income and franchise taxes and property taxes. Your
\> > memo dated October 31, 2005, requests the repeal of personal
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\> > Please note that both of these requests involve some complicated
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> > refuses to meet, thereby holding up or killing every bill that is
> > referred to the committee.
> >
> > Please contact me if you have any questions.
> >
> > Joe
> >
> > Joseph T. Kreye
> > Senior Legislative Attorney
> > Legislative Reference Bureau
> > (608) 266-2263
> >
> >
>

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www.wisconsinhealthplan.org

Memo

To: Representative Richards

From: Pam Kahler

Subject: Statutory sections to review

Date: January 5, 2006

The following is a list of statutory sections in current law related to health insurance, health care plans, and other issues that might be affected by, or that might affect, the health insurance purchasing proposal in LRB–2922. These sections should be reviewed to determine if any of them need to be repealed or amended to harmonize current law with the proposal in LRB–2922. This list will be provided to David Riemer and Lisa Ellinger this afternoon.

- 21.80 (6)
- 45.351 (1j)
- 46.286
- 49.46 (1) (m) 1. and 2. and (2) (a) 6.
- 49.47 (4) (cm) 1. and 2.
- 49.473 (2) (c)
- 49.68, 49.683, 49.685, and 49.686
- 59.52 (11) (c)
- 62.61
- 66.0137 (3), (4), (4m) (b), and (5)
- 103.10 (9)
- 103.49 (1) (b) and (d) 1. and 2.
- 103.50 (1) (d) 1. and 2.
- 109.075 (2) and (6)

2

- 111.35 (3) (a) (intro.) and 2. and (b) (intro.) and 2.
- 111.70 (1) (dm)
- 111.91 (2) (n) to (s)
- 120.12 (24)
- 120.13 (2) (b) and (g)
- ch. 149 (Repeal HIRSP)
- 153.01 (4h) and (4p)
- 252.16
- 252.17
- 254.11 (13)
- 255.06
- 601.41 (8)
- 609.10
- 609.20 (1m) (c) and (d)
- 628.36
- subch. VI of ch. 632 (subchapter regulating health insurance; includes the "mandates")
- ch. 633 (note definition of "administrator" in s. 633.01 (1))
- ch. 635 (small employer health insurance)
- 767.25 (4m) (d)