The Health Insurance Exchange

The Solution:

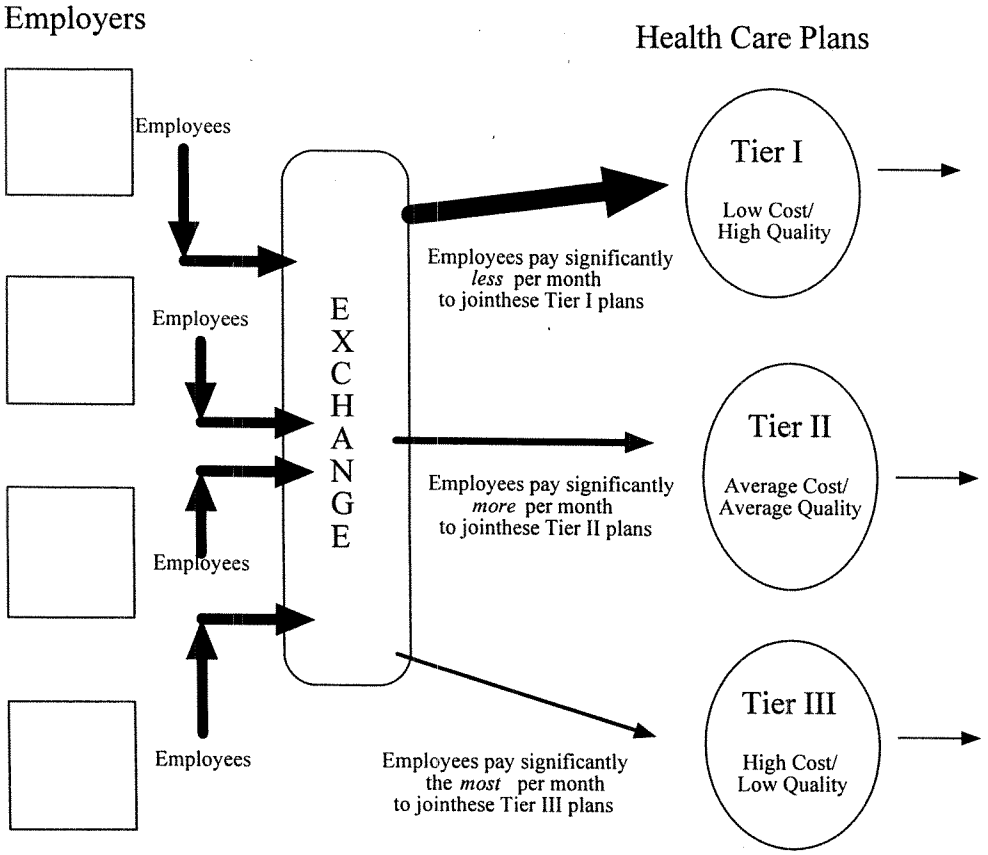
¥Lower EmployersÕ Costs by:

¦ Giving Employees Clear Economic Incentives to:

--Join Low-Cost, High-Quality Health Care Plans

Question: How would the Exchange give employees clear economic incentives t join low-cost, high-quality health care plans?

Answer: By ranking the health care plans into ÒtiersÓ based on their cost and quality, and then requiring employees to pay significantly *less* out-of-pocket per montl to enroll in Tier I (low-cost, high-quality) plans *more* each month to join Tier II (average average cost/quality)s plan...and the *most* each month to join Tier III (high-cost, low-quality plan).



who "ranks" the plans?

how would a lower premium for Tier 1 ensure that Tier 1 has the lowest risk employees?

(for both plans risk and employer cost = lowest prem to plan w/ lowest risk employees & employers with lowest risk employees)

The Solution:

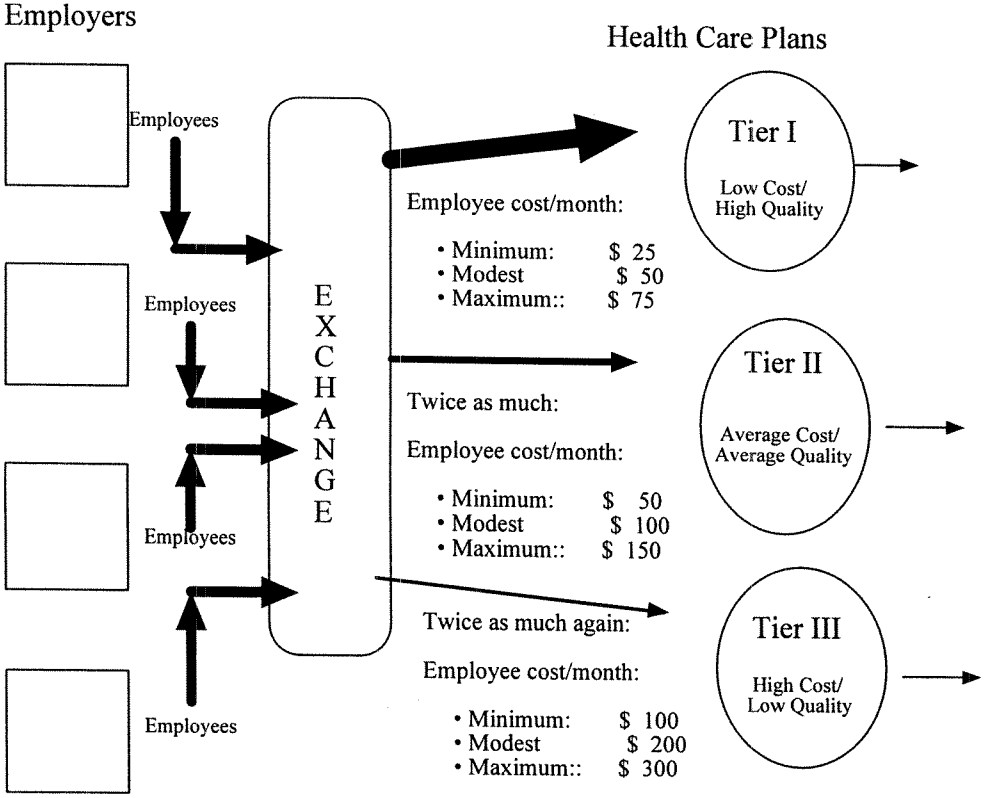
¥Lower EmployersÕ Costs by:

¦ Giving Employees Clear Economic Incentives to:

--Join Low-Cost, High-Quality Health Care Plans

Question: How much more should employees pay to join Tier I plan > a Tier II plan, or a Tier II plan > a Tier III plan? And how should these "employee Tier differentialsÓ (E-TierÆ) be set to *encourage* employees to join a low-cost (Tier I) plan yet *allow* higher-cost (Tier II and Tier III) plans to be truly affordable choices?

Answer: To create strong incentives to choose Tier I > Tier II and Tier II > III, the Exchange should set the E-TierÆ so that it costs the employee roughly *twice* to join a Tier II plan > a Tier I plan, and *twice* as much again to join a Tier III plan > a Tier II plan. But to make all plans affordable, the E-TierÆ should probably not exceed $150/month, or the maximum Tier III plan cost should not exceed $300/mont



The Solution:

¥ Allow Employers, Employees, Plans and Providers Freedom of Choice...Provided<u>They</u> Pay the Higher Price of Higher-Cost Choices

Question: Does the Exchange really give employers, employees, plans and providers freedom of choice?

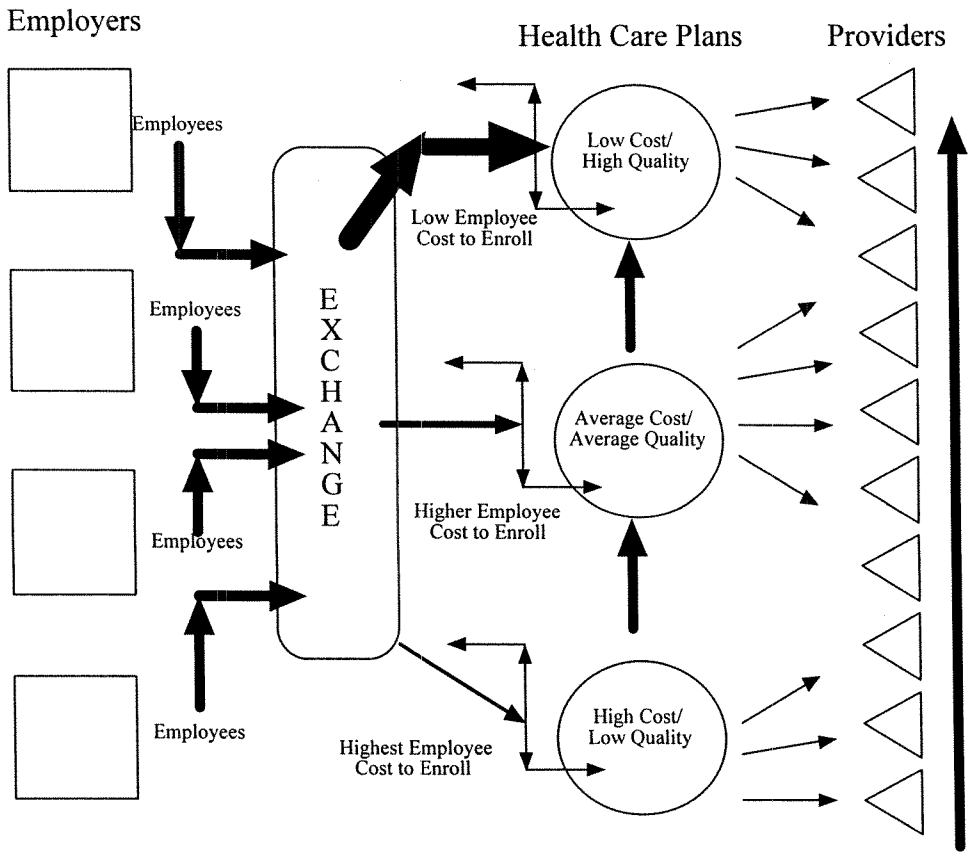
Answer: Yes. The Exchange gives all participants real choice...and choice whe they need it most.

¥ Employers can choose the level of benefits and level of employee premium-sharing they want...dialing up or down their costs accordingly. See next chart.

¥ Employees get a choice most of them now donÕt have: a choice of health pla plus good information and prices to help them make the right choice.

¥ Plans and providers choose whether to participate, and what prices to charg

do employers choose whether to participate ?



Employer Flexibility: 9 Plan Options

Benefit Package Options

More <<<<<< Benefits >>>>>> Less

Lower <<<< Deductibles/Co-Pays >>>> Higher

Worker Premium-Sharing Options:	**Deluxe**	**Generous**	**Basic**
Minimal: **Tier I: $25** **Tier II: $50** **Tier III: $100**	**Highest Employer Cost**	High Employer Cost	why none?
Modest: **Tier I: $50** **Tier II: $100** **Tier III: $200**	High Employer Cost	why none?	Low Employer Cost
Maximum: **Tier I: $75** **Tier II: $150** **Tier III: $300**	why none?	Low Employer Cost	**Lowest Employer Cost**

Different Costs Per Worker Per Month to Enroll in Different Plans Based on Cost/Quality--

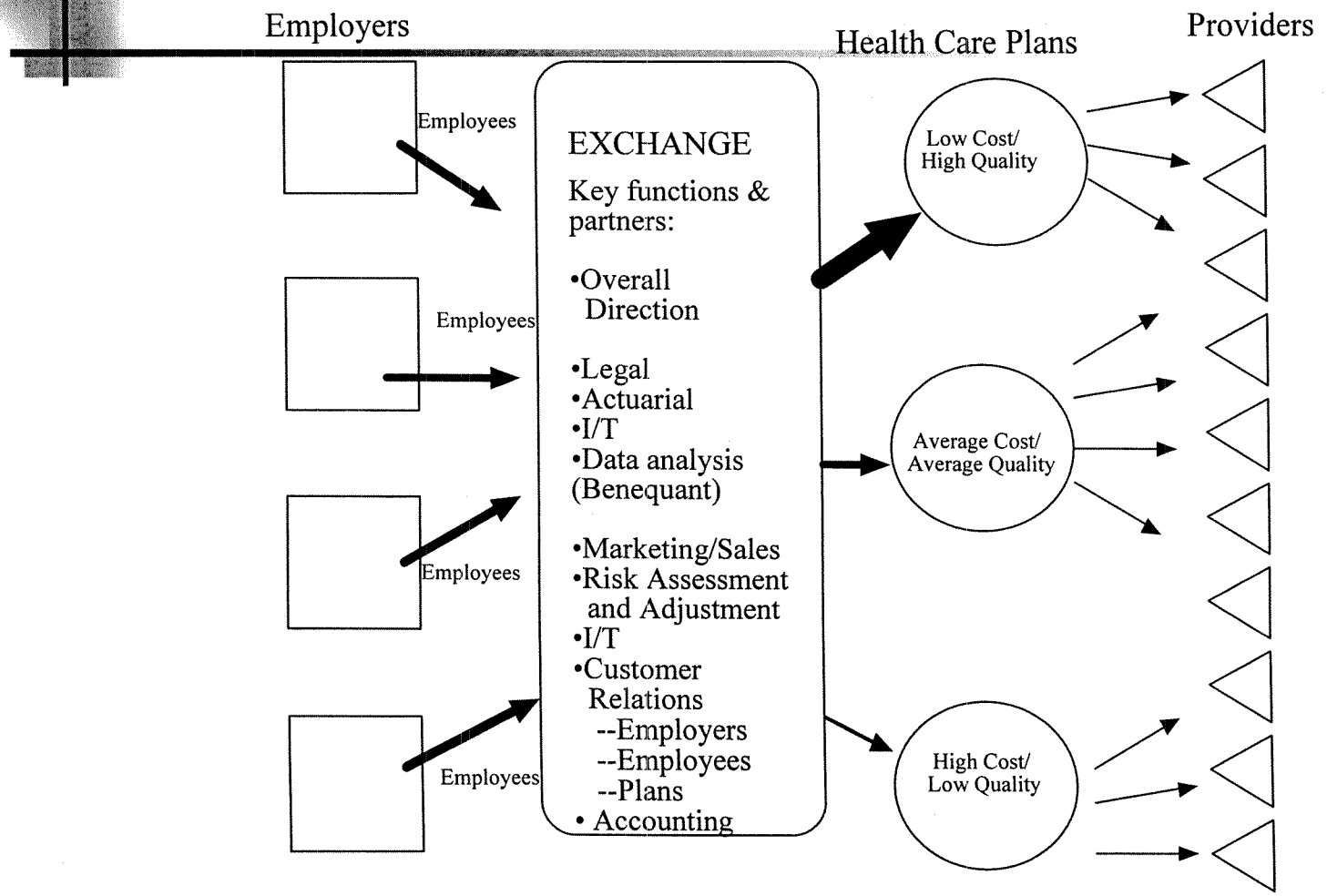
Tier I Plans= Lower Cost/ Higher Quality

Tier II Plans = Average Cost/ Average Quality

Tier III Plans = Higher Cost/ Lower Quality

Creating and Managing the Exchange

For the Exchange to get off the ground, two things are key:
1. Either the legislature must require its creation, or a committed government leader or employer organization must organize it; and
2. The right managers must be chosen to operate it.



The Health Insurance Exchange

Moving Employers' Health Insurance Dollars To Lower-Cost, Higher-Quality Health Care

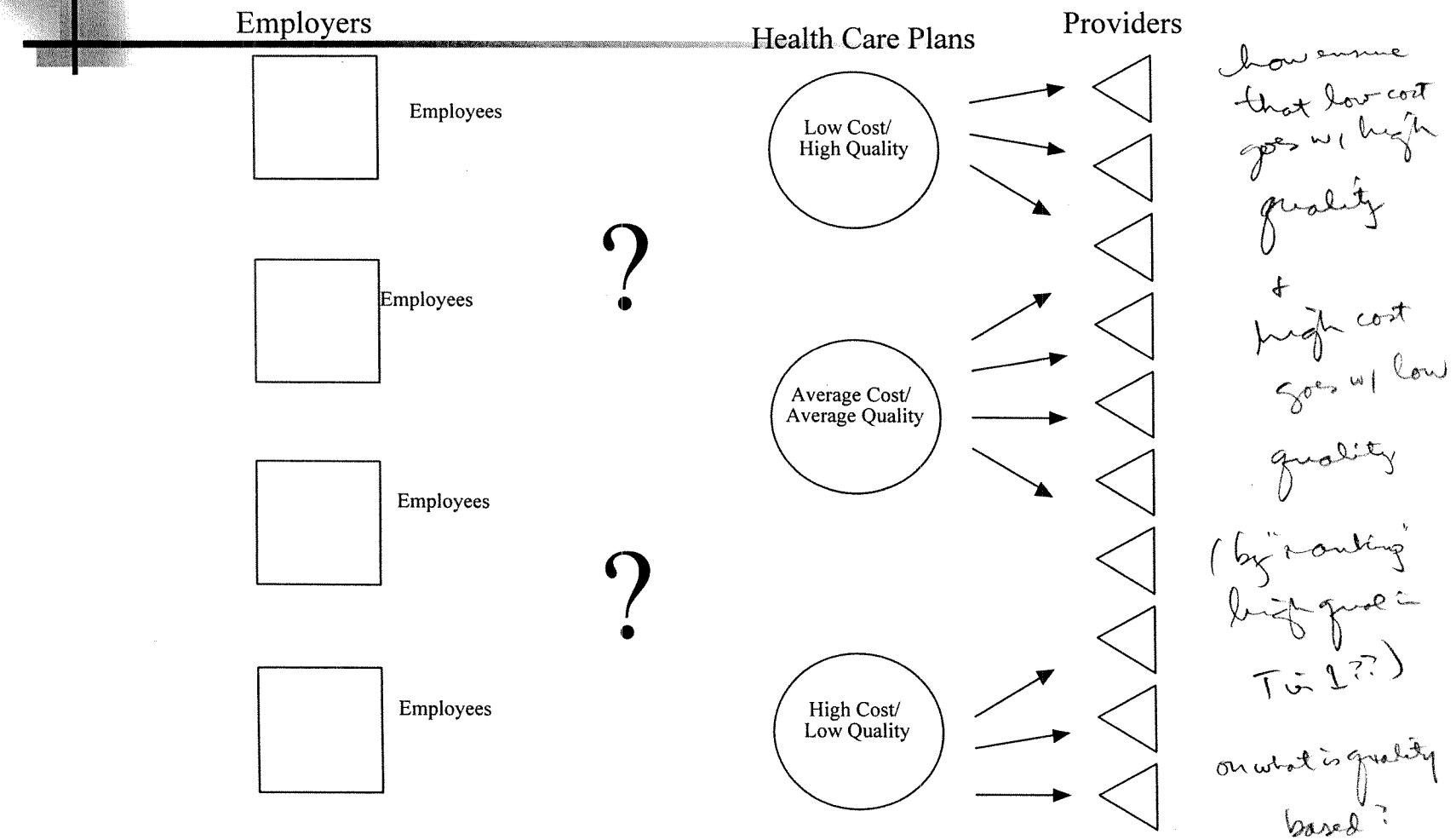
The Health Insurance Exchange

David R. Riemer

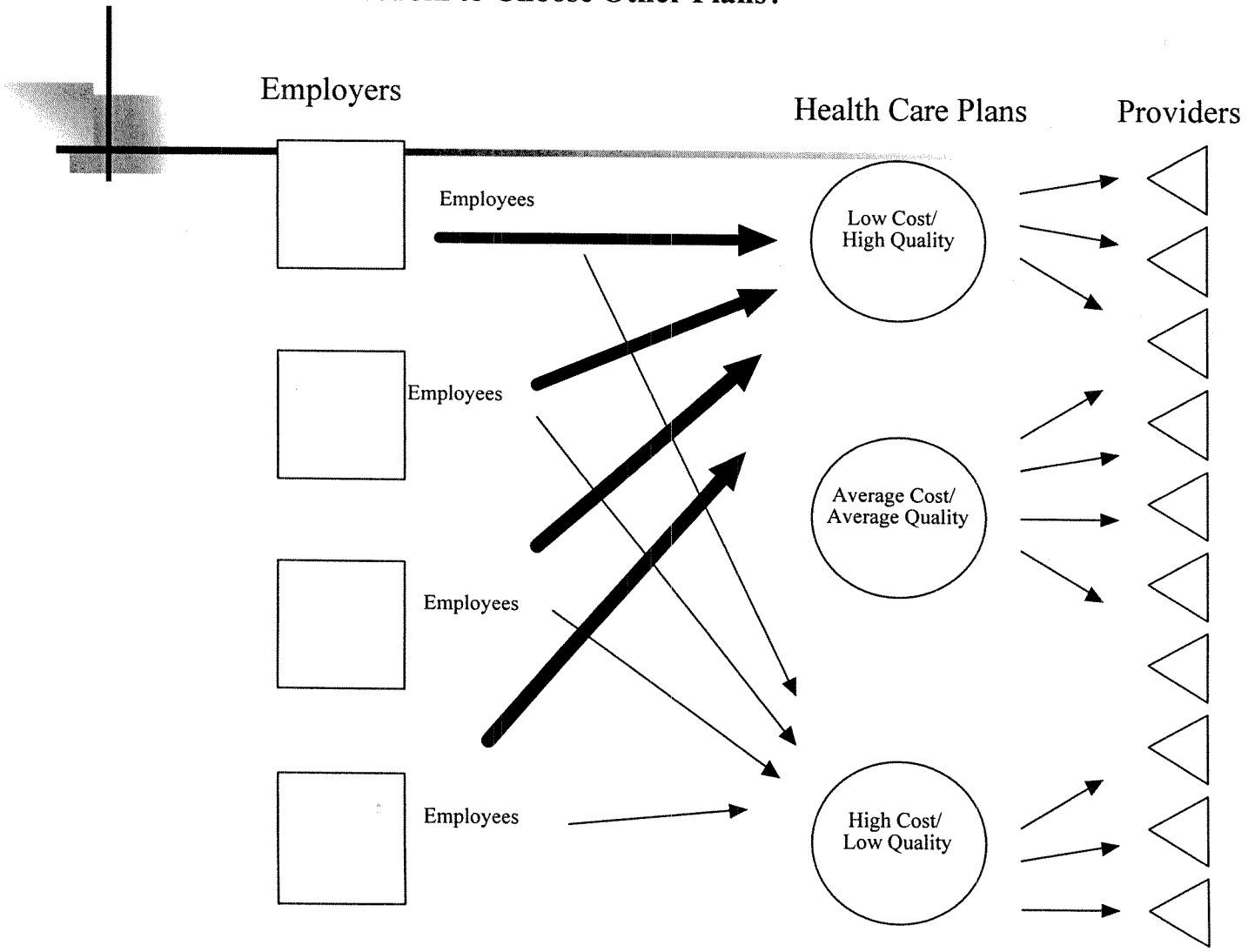
Based on the work of Alain Enthoven,
Professor of Economics, Stanford University
and
Thomas Korpady,
State of Wisconsin Employee Health Plan
Florence Dukes & Michael Brady
City of Milwaukee Employee Health Plan

The Health Care Question: How To Organize the Relationships Between Employers and Employees With Different Risk Profiles (On One Side) and Health Care Plans and Providers Of Differing Cost & Quality (On the Other Side) in a Manner That:

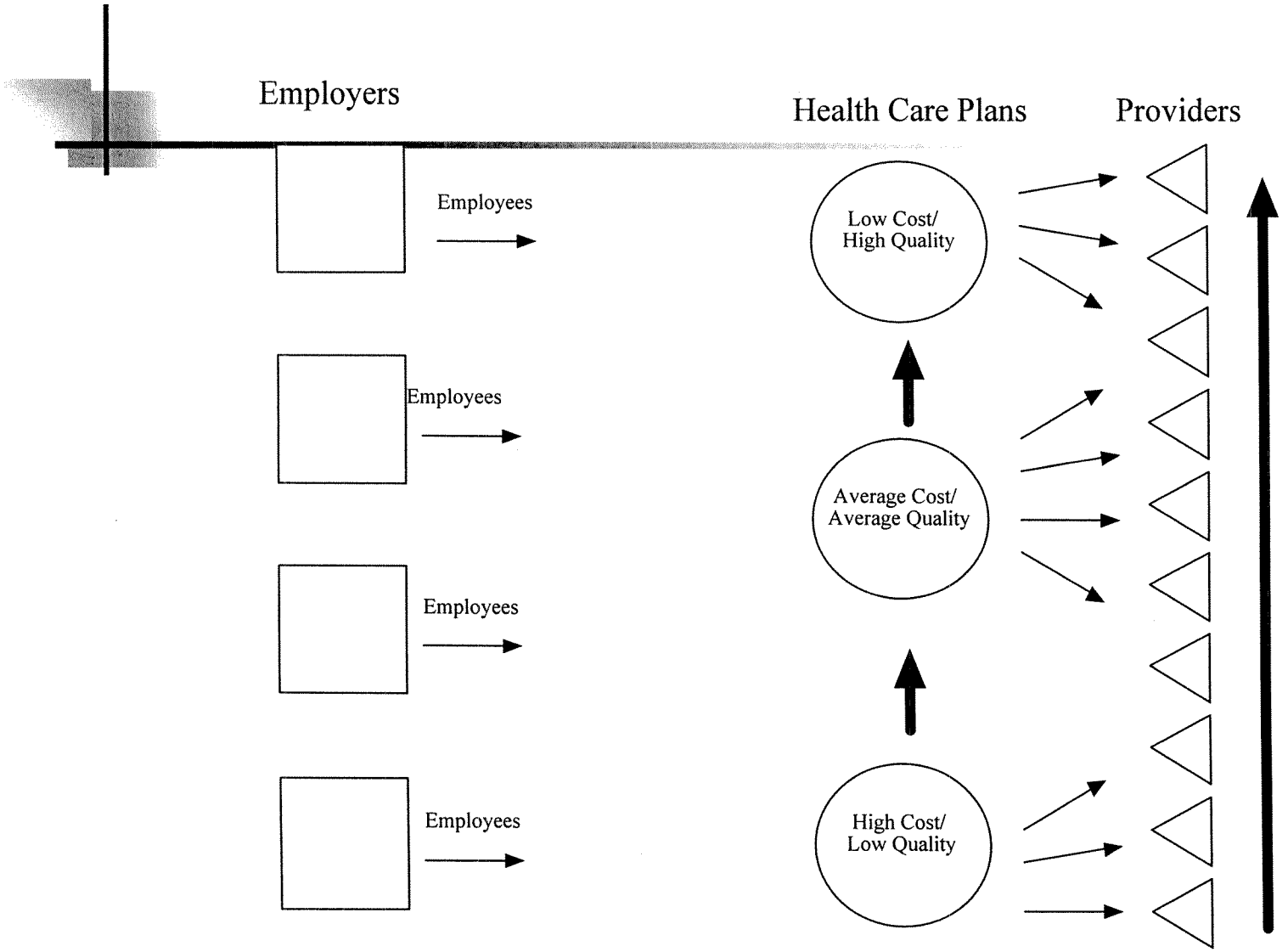
- **¥ Lowers EmployersÕ Health Cost and**
- **¥ Preserves EmployersÕ, EmployeesÕ, PlansÕ, and Providers Free Choice ?**



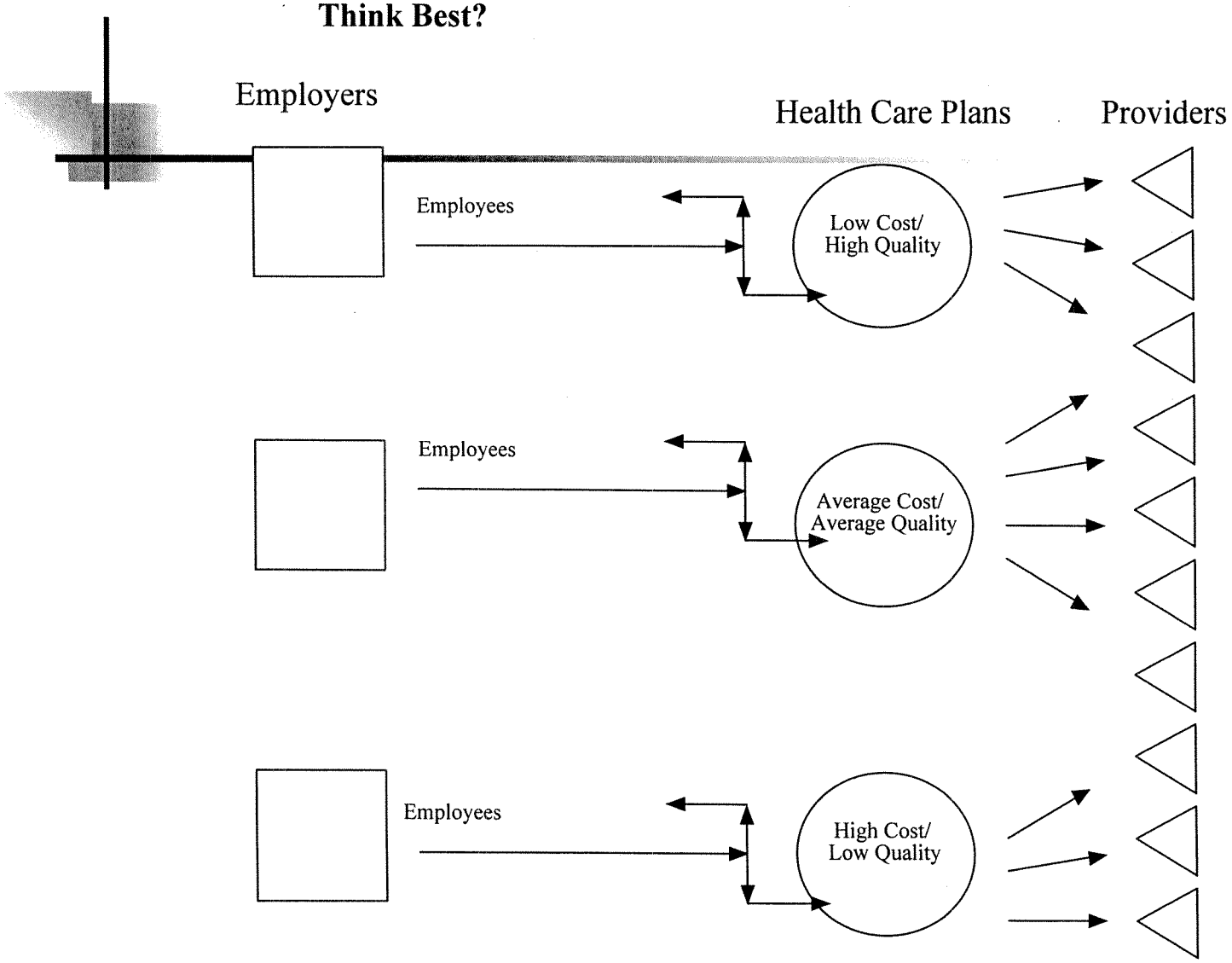
Challenge #1: How to Induce Employees to Join Low-Cost, High-Quality Health Care Plans...While Preserving Their Freedom to Choose Other Plans?



Challenge #2: How to Induce Health Care Plans and Providers to Lower Their Cost & Raise Their Quality ... While Respecting Their Right to Operate As They Prefer ?



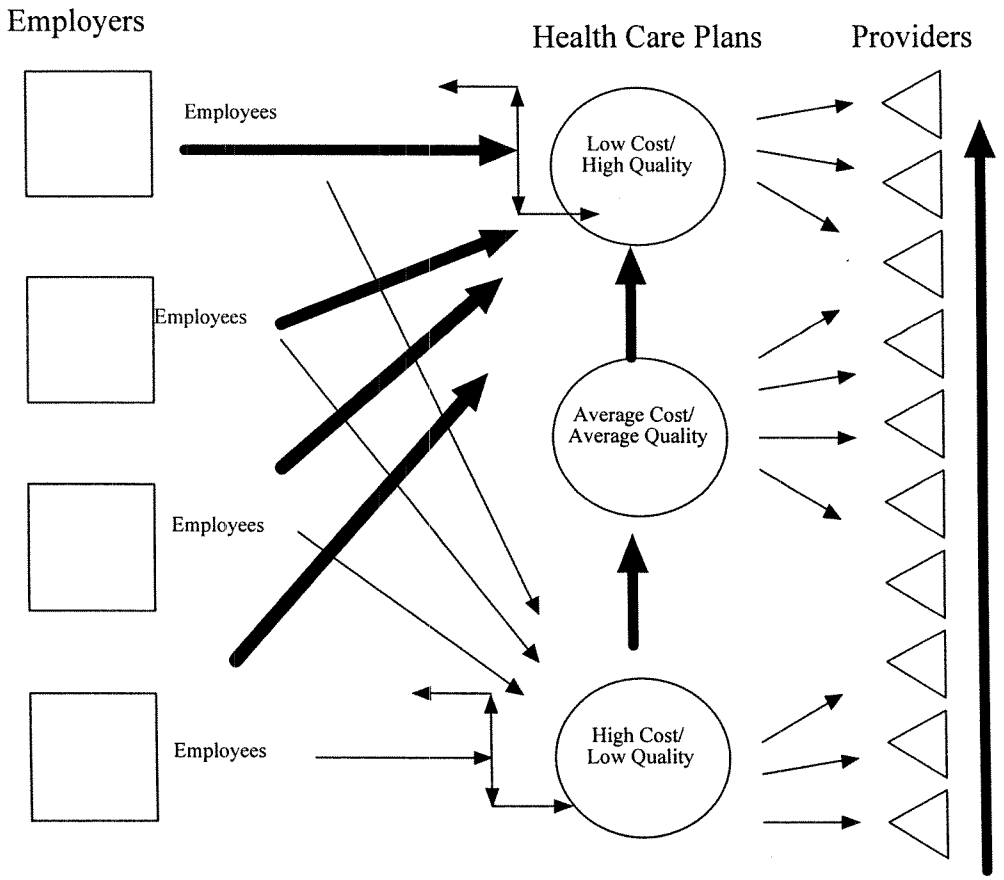
Challenge #3: How to Get Enrollees to Prudently Use Their Health Care Plans... While Preserving Their Right to Freely Make Whatever Health Care Decision They and Their Doctors Think Best?



How to ÒDo It AllÓ--How To Meet All the Challenges at the Same Time?

¥ **Lower EmployersÕ Costs By Inducing:**
- **Employees to Join Low-Cost, High-Quality Health Care Plans**
- **Health Care Plans to Lower Cost & Raise Quality**
- **Employees to Prudently Use Their Health Care Plans**

¥ **Still Allow Employers, Employees, Plans and Providers to Exercise Freedom of Choice**



The Solution:

¥Lower EmployersÕ Costs by:

¦Having Multiple Employers Use a Single Agent--and a Single Set of Rules--to Buy Health Care Coverage for Their Combined Bloc of Employees (= Purchasing Pool)

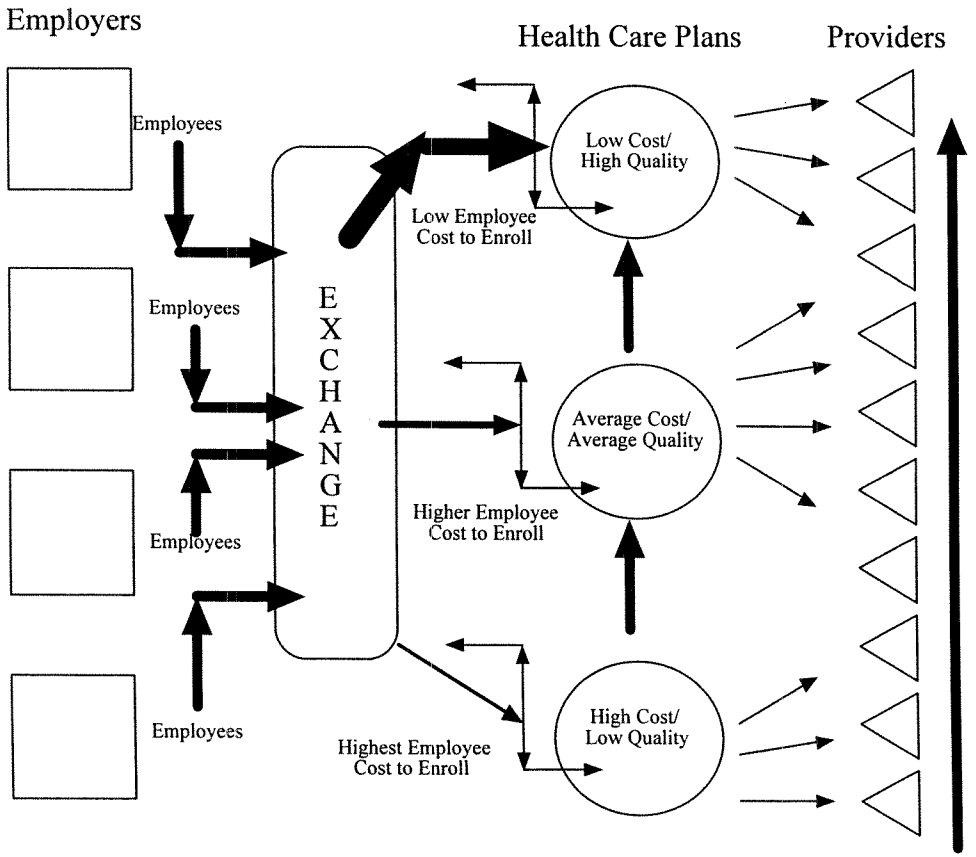
¦ Giving Employees Clear Economic Incentives to:

--Join Low-Cost, High-Quality Health Care Plans

--Prudently Use Their Health Care Plans

¦ Structuring These Employees Incentive To Lure Health Care Plans to Lower Their Costs and Raise Their Quality

¥ Allow Employers, Employees, Plans and Providers Freedom of Choice...ProvidedThey Pay the Higher Price of Higher-Cost Choices



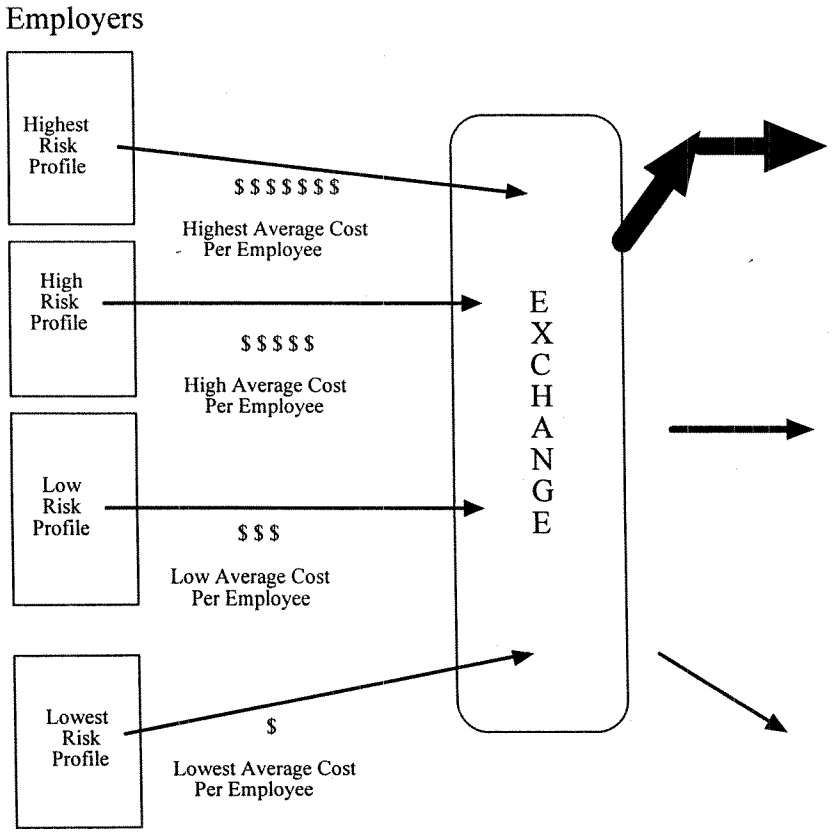
The Solution:

¥Lower EmployersÕ Costs by:

¦Having Multiple Employers Use a Single Agent--and a Single Set of Rules--to Buy Health Care Coverage for Their Combined Bloc of Employees (= Purchasing Pool)

Question: WonÕt this result in Òadverse selectionÓ, under which high-risk employers (e.g., due to older employees and other risk factors) want to join the pool because it saves them money, while low-risk employers (e.g., due to younger employees and other risk factors) avoid or leave the pool because it costs them more than they could otherwise buy in the insurance market... thus causing a Òdeath spiraÓ that ultimately destroys the pool?

Answer: No, because each employer pays for its own risk profile through Òrisk adjustmentÓ-- not the total risk presented by the Exchange.



What is advantage of joining if pay for own risk anyway?

What factors for "risk adjustment" and who decides?

The Solution:

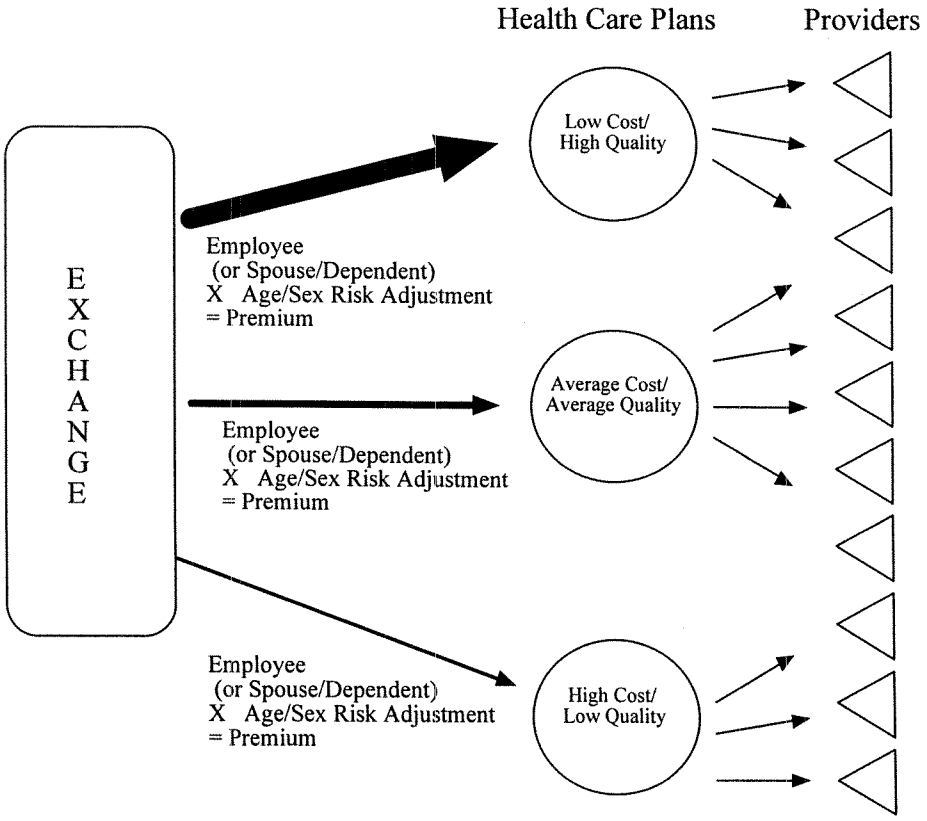
¥Lower EmployersÕ Costs by:

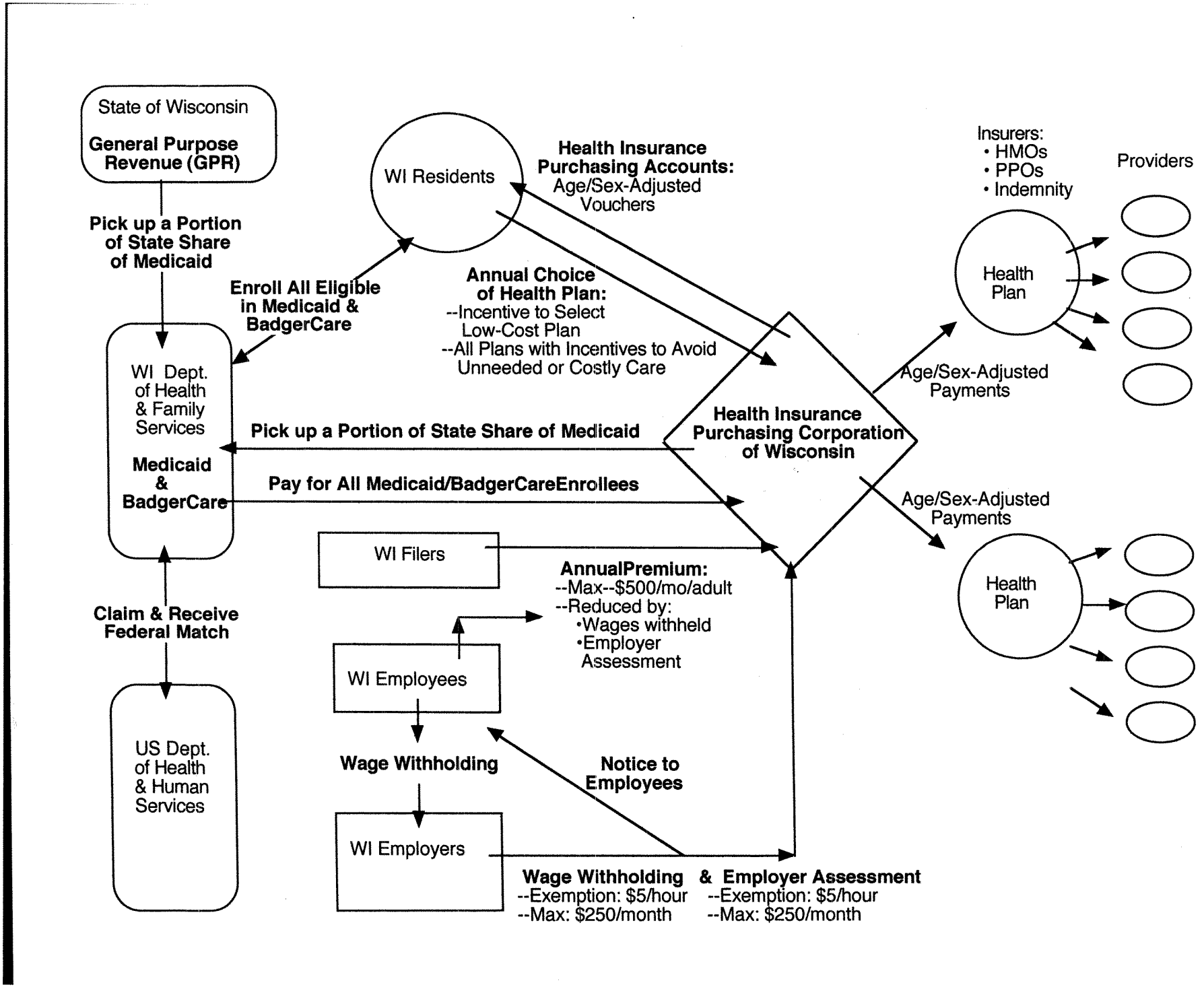
¦ Structuring These Employees Incentive To Lure Health Care Plans to Lower Their Costs and Raise Their Quality

Question: How to overcome each health care planÕs fears that, out of a large pool of employees, it will be stuck with a disproportionate share of the high-ris employees (e.g., the older ones) and paid too little premium to cover its costs...no matter how cost-effective the health care plan may be?

Answer: Pay premiums to each plan based on the actual risk that each enrollee presents to the plan (i.e., adjust premium payments up or down, depending age, sex, and other risk factors).

what factors — who decides?




State of Wisconsin
General Purpose Revenue (GPR)
Pick up a Portion of State Share of Medicaid
WI Residents
Health Insurance Purchasing Accounts:
Age/Sex-Adjusted Vouchers
Insurers:
• HMOs
• PPOs
• Indemnity
Providers
Health Plan
Enroll All Eligible in Medicaid & BadgerCare
Annual Choice of Health Plan:
--Incentive to Select Low-Cost Plan
--All Plans with Incentives to Avoid Unneeded or Costly Care
WI Dept. of Health & Family Services
Medicaid & BadgerCare
Age/Sex-Adjusted Payments
Pick up a Portion of State Share of Medicaid
Health Insurance Purchasing Corporation of Wisconsin
Pay for All Medicaid/BadgerCareEnrollees
Age/Sex-Adjusted Payments
WI Filers
AnnualPremium:
--Max--$500/mo/adult
--Reduced by:
•Wages withheld
•Employer Assessment
Health Plan
Claim & Receive Federal Match
WI Employees
US Dept. of Health & Human Services
Wage Withholding
Notice to Employees
WI Employers
Wage Withholding & Employer Assessment
--Exemption: $5/hour
--Max: $250/month
--Exemption: $5/hour
--Max: $250/month

Kahler, Pam

From: Kostelic, Jeff
Sent: Thursday, January 13, 2005 4:17 PM
To: Kahler, Pam
Subject: HIPCO - proposed modifications to /1

Condensed Riemer Memo of Decem...

Pam,

Thank you for pulling together the first draft of this very complex bill in such a short period of time. We are all very pleased to see something in writing given that this concept has been discussed for over ten years without ever being formally drafted. Attached, please find a rather lengthy memo detailing Representative Richards' proposed changes and additions to /1.

Please do not hesitate to contact Representative Richards or David Riemer if you have any questions about this memo or if you need additional information.

Thank you for all of your work on this project.

Jeff Kostelic
Office of Representative Jon Richards

(1)

MEMO

To: Pam Kahler

From: Representative Jon Richards

Date: January 13, 2005

Re: Health Care Exchange/HIPCO

The proposal I envisioned calls for a new Health Insurance Purchasing Corporation (Corporation) that (1) assigns individual Health Insurance Purchasing Accounts (Accounts) to most Wisconsin residents for the purpose of enabling them to purchase a basic health insurance package, (2) finances these Accounts by assessing (with the help of DOR) those covered persons who are adults as well as through an off-setting wage assessment of employees and employers, and (3) is silent about what employers may do with respect to the provision of health insurance.

Basic Changes:

1.) The term, "Statewide Comprehensive Plan" implies a large, inflexible, government-run program with lots of bureaucracy and red tape. This gets away from my original intent, which was to create a small, flexible, privately-administered Health Insurance Purchasing Corporation. At the heart of this plan is a reliance on the private-sector approach of giving individuals accounts they control.

2. The term, "income tax surcharge" implies that the revenues raised are indeed general tax revenues that *could* be used for any governmental purpose. To avoid confusion, it would be preferable to include language that the Corporation would be requiring people to pay dollars for a specific purpose, i.e., establishing and financing of health Insurance Purchasing Accounts refers to the Corporation's revenue-raising authority as that of imposing an assessment.

Can a private corp do this? (tax)

✓ 3. The language on page 9, lines 12-17, of the draft, by indicating that employers *can* provide supplemental health insurance benefits, creates the negative inference that employers *cannot* provide any other kind of health insurance coverage. This inference violates ERISA, and if embraced by the courts could result in the entire proposal's being struck down as contravening federal law. To address this issue, please remove p. 9, lines 12-17 and lines 18-19. In other words, remove Sec. 260.25 altogether.

Detailed Comments

(2)

relating clause

Page 1, lines 3-4. Consistent with the general comments made above, replace "statewide health insurance plan and creating an individual income surtax" with something like "authorizing a health insurance purchasing corporation to establish health insurance purchasing accounts and implement an assessment".

P. 1, line 9. Consistent with the general comments made above, replace *"Statewide Comprehensive Health Insurance Plan of Wisconsin"* with *"Health Insurance Purchasing Corporation of Wisconsin"*.

P. 2, lines 1-2. Consistent with the general comments made above, (a) after "Health Insurance Purchasing Corporation of Wisconsin for", delete "the", and (b) after "costs" delete the remaining words.

Or, better yet, delete everything after "Health Insurance Purchasing Corporation of Wisconsin". Is it even necessary to specify "for operating and administrative costs"?

more language

P. 2, line 4, through P. 3, line 18. Consistent with the general comments made above, I would recommend moving this entire section *out* of the income tax section of the statute and incorporating it in the new Chapter 260, i.e., including *within* the chapter on the structure and powers of the Health Insurance Purchasing Corporation of Wisconsin the specific authority of the Corporation to assess individuals and employers.

Limited cross-references to Chapter 71 and its definitions of taxable income and household types (i.e., single individuals, heads of households, married persons filing separately, and married persons filing jointly) are OK, for the purposes of determining the amount of the assessment on individuals. But such references to taxation, taxable income, tax rates, rates, and anything else that sounds like taxation should be kept to a bare minimum.

There are also some problems with the way the assessment formula is expressed.

On p. 2, lines 8-11, there's no reference to the intended *cap* on the assessment, which my model sets at $500/month or $6,000/per year, for single individuals, heads of households, or married persons filing separately.

On p. 2, lines 12-14, same problem. My model sets a *cap* of $1000/month or $12,000 per year for married persons filing jointly.

On p. 2, lines 16-19, In the context of a system of assessments, the language dealing with income tax rate changes seems misplaced. Can this be eliminated?

P. 2, line 20, through p. 3, line 7: Consistent with the general concern that the Wisconsin income tax system should not swallow up the mechanism by which the Corporation implements its assessment authority, I would completely change the language dealing with part-time residents. The intent of my model, in the case of individuals who qualify as Wisconsin residents during the course of a coverage year, i.e., who are part-year residents, was to allow them to acquire Health Insurance Purchasing Accounts, use their Accounts to buy health insurance, and be assessed by the Corporation for whatever portion of the year (11 months, 10 months, etc.) applies. "Domicile" in Wisconsin *per se*, by the way, which the LRB language refers to on P. 2, line 22 , and P. 3, line 4, should not be the decisive factor. Rather, duration of "resident" status—i.e., legally domiciled for at least 6 months (with a special rule for children) as proposed Sec.

maybe that's because you haven't sent instructions as I requested you to do

(3)

260.01(4), on P. 4, lines 4-10—is the key. On p. 5 of the latest draft of Model #1 (2nd draft, 12/6/04), I utilize the concept of "Coverage Factor" to get at how to translate an individual's part-year resident status into a factor that is then used to proportionately reduce the assessment the individual owes the Corporation. Perhaps this is the wrong approach; but it comes closer to the original idea than the surtax-based, domicile-based language in 0950/1.

P. 3, lines 9-13. The intent of my model is to authorize the Corporation to implement two separate assessments: one on Wisconsin residents, the other on Wisconsin employees/employers. The first (resident) assessment is meant to be reduced by the second (employee/employer) assessment, based upon the resident receiving an annual statement from the employer about how much was assessed at the workplace. But my model treats them as two distinct assessments, which happen to have a rule that defines their relationship. I can't tell from this language (which, as mentioned above, needs to be moved to Chapter 260, "de-taxed" and re-expressed as an assessment) whether LRB 0950 actually would create the second (employer) assessment.

A second problem is the omission of the specific formula for the employee/employer assessment. The following formula should be included in the draft: first $5/hour of wages exempt, 10% assessment on wages above $5/hour, but cap of $500/month or $6,000/year. **I believe it's very important to express this formula in the bill, to set an explicit limit on the Corporation's authority to assess.** The legislation should set this formula as a maximum, i.e., authorize the Corporation to implement an assessment *not to exceed* the formula.

Two other specific features you may want to include in the language on the assessment formula, and I'd recommend at this point:

• Authorizing the Corporation to impose a lower assessment on small employers. I think the easiest way to do this is not to spell out a specific formula, but to authorize the Corporation to reduce the assessment for employers whose total wages are less than $500,000 per year. (The formula I'm thinking of is: 5% on 1st $100,000 of wages, 6% on next $100,000, 7% on next $100,000, 8% on next $100,000, 9% on next $100,000, and finally 10% on remaining wages. But I believe it would be a mistake to get this specific in the legislation.)

•Authorizing the Corporation to impose a lower assessment on any employer (regardless of size or wage base) that has in place an effective "wellness" program that meets scientifically based standards established by the Corporation.

A third modification is needed to address an issue with the 25%/75% split between employee/employer. The intent was to *start* with 25% of the assessment being paid for by the employee, and to *start* with the remaining 75% as the assessment being paid for by the employer. However, the employee and employer—or, where the employees are represented by a collective bargaining agent, the employees' union and the employer—would be free to negotiate a deal where any part (including all) of the employee's "share" can be picked up by the employer. I'm concerned that 0950/1 could be read to preclude such a "pick up" of the employee's share by the employer, i.e., could be read to fix the 25%/75% split as unalterable. The split should be unalterable in terms of *increasing* what the employee ends up paying for health insurance. (As the Drafting Note accurately states, on p. 2, in the middle, there is a possibility that the employer could modify its pay structure so as to lower its workers *wages* to offset what the

employer considers to be an excessive health insurance assessment by the Corporation. I accept that risk. But its goal is to block any explicit increase in the employee's share of the Corporation's health insurance assessment above 25%.) But the split was meant to be open-ended in terms of *decreasing* below 25% what the employee ends up paying for health insurance (notwithstanding the risk that such a decrease might be offset, as the LRB points out, on the wage side).

P. 3, lines 15-18. Consistent with the general comments above, this paragraph should be deleted.

P. 3, line 24, and p, 4, line 3. I would prefer to allow the Corporation itself to define what's a generic drug and what's a brand name drug. I don't know the origin of the Sec. 450.12 definitions that are cross-referenced here, and don't dispute that they may be just fine. But why not let the Corporation make this call?

P. 4, line 7. As drafted, a child who lives in Wisconsin, and whose parent or guardian is domiciled in Wisconsin *for any amount of time* (even for a very short time), could be a Wisconsin resident for purposes of acquiring a Health Insurance Purchasing Account. This would allow a parent with a sick child to move from Chicago to Kenosha or St. Paul to Eau Claire and quickly obtain coverage for the child (though not herself or himself) at the expense of Wisconsin taxpayers. This was not my intent. Rather, the intent was to let children become Wisconsin residents regardless of the duration of their residency (typically, because they'd just been born in Wisconsin) *only if* parents had been domiciled in Wisconsin for *at least* 6 months. So line 7 should be written to read (after "guardian"): "has been legally domiciled in this state for a period of at least 6 months."

A further separate point: There needs to be a mechanism for allowing certain small groups of Wisconsin residents—prisoners, individuals cared for in institutions for the mentally ill or developmentally disabled, and perhaps some others—to be exempted, for obvious different reasons, from having active Health Insurance Purchasing Accounts. Sec. 260.15(1)(a) and (b) on "Who Is Covered" on P. 7, Lines 12-19, properly excludes coverage for persons 65 or older and federal employees. But a wider exclusion is needed.

P. 4, lines 11-12. Consistent with prior remarks, delete the definition of a "Statewide Comprehensive Health Insurance Plan of Wisconsin." This might, however, be a good place to insert a definition of a Health Insurance Purchasing Account.

P. 4, lines 16-17. The effort to exempt the Corporation from federal taxation is fine. But what about state taxation? Is that implicit? Or does that need to be spelled out somewhere?

P. 4, line 22, through P. 5, line 1. This paragraph on the structure of the Corporation's board of directors should be rewritten, in response to the 2 questions on P. 5,as follows:

"2. That the corporate board shall consist of 6 directors, of whom 1 shall be chosen by the head of Wisconsin Manufacturers and Commerce, 1 shall be chosen by the head of the Metropolitan Milwaukee Association of Commerce, 1 shall be chosen by the head of the Wisconsin Federation of Independent Business, 1 shall be chosen by the

head of the Wisconsin American Federation of Labor Congress of Industrial Organizations (AFL-CIO), and 2 shall be chosen by the Governor and confirmed by the Senate. All directors shall serve for terms of 6 years, except that the initial director chosen by the Metropolitan Milwaukee Association of Commerce and one of the initial directors chosen by the Governor shall serve for a term of 4 years, and the initial director chosen by the head of the Wisconsin Federation of Independent Business and the other initial director chosen by the Governor shall serve for a term of 2 years."

Consistent with this change, the authority of the Secretary of DOA on p. 5, line 1, to designate the initial directors should be repealed.

In response to the first note and question on the top of P. 5, I think it best to let the board of directors select its own chairperson.

P. 5, line 5. Consistent with comments made above, this should be deleted and replaced with something like:

"Establish Health Insurance Purchasing Accounts for all residents [NB: now a defined term] and assist residents in using their accounts for the purchase of adequate health insurance coverage from qualified insurers."

P. 5, lines 6-9. **This comment also relates to P. 9, line 20 through P. 10, Line 12.** These provisions capture the original intent, but I think they need to be modified to reflect three realities: (1) the Wisconsin Department of Health and Family Services (DHFS), not the Corporation, has exclusive authority (under federal law as well as practice) when it comes to dealing with the U.S. Department of Health and Human Services (US/DHHS) on all Medicaid matters; (2) DHFS needs to be authorized and directed to seek waivers to integrate the "family" portion of Medicaid plus BadgerCare into the new system of Health Insurance Purchasing Accounts, and (3) since #2 will take some time to accomplish, the Corporation needs authority simply to pay DHFS the ca. $400-500 million/per year state share of the "family" portion of Medicaid and BadgerCare until such time as waivers are OK'd and the integration of M/A and BadgerCare is complete.

The following three modifications are needed.

First, we need language (separate from Chapter 260, presumably in the statutory sections relating to DHFS) that authorizes and directs DHFS *in cooperation with the Corporation* to seek Section1115 and other appropriate Medicaid and SCHIP waivers from US/DHHS for the purpose of fully integrating the "family" portion of Medicaid and BadgerCare as a whole—though with enrollees paying substantially less in cost-sharing—into the Corporation's consumer-driven Health Insurance Purchasing Account mechanism for providing adequate health insurance coverage to all Wisconsin residents under age 65.

Second, we need language that authorizes and directs the Corporation to pay DHFS ca. 4$400-500 million/year, i.e., the state share for the "family" portion of Medicaid and the state share of BadgerCare.

Third, we need language that authorizes and directs DHFS and the Corporation to work together—once the waivers integrating the "family" portion of MA and BadgerCare into the Corporation's system of Health Insurance Purchasing Accounts has been

accomplished—to ensure that the largest possible number of Wisconsin residents are enrolled in MA and BadgerCare for purposes of maximizing federal reimbursement.

Please review the text on P. 5 as well as on PP. 9-10 to determine if they accurately capture these three points.

P. 5, line 10. The LRB language assumes that the Corporation's fiscal year will be the *same* as the state's fiscal year. Is this necessary? How about deleting "state" before "fiscal year"?

Also, the reference to "statewide plan" should be deleted. Replace with something like: "system of Health Insurance Purchasing Accounts".

P. 6, line 3. Replace 'statewide plan" with "Corporation".

0950/1 asks (in the note between lines 7 and 8) whether, instead of a mandatory biennial LAB audit, the Secretary of DOA should be authorized to order independent audits. I would prefer the LAB audit the Corporation every two years, even though—as LRB points out—it's highly unusual. [Note that on P. 1, lines 6-7, the Corporation is required to pay the costs for such an audit.]

Related to this audit: I think it would also be a good idea to require the Corporation to submit an annual report to the Legislature and Governor. The Corporation would probably do this anyway. But as part of a general policy of transparency and accountability, I think it wise to make the requirement explicit.

P. 6, lines 8-14. Consistent with prior comments, this needs to be rewritten to eliminate reference to a "Statewide Comprehensive Health Insurance Plan." What would be the practical impact of eliminating this entire paragraph?

P. 6, line 18. Rather than "participate", I'd suggest, "submit a bid." The use of "participate" suggests that any insurer who does submit a bid is guaranteed the right to be offered to Wisconsin residents with Health Insurance Purchasing Accounts. However, the Corporation might disqualify bidders for good cause, e.g., failure to submit required information.

P. 6, lines 19-21. . Please re-write this section, partly to remove references to "statewide plan". I'd suggest something like: "The corporation shall seek to ensure that residents, in using their Accounts to purchase health insurance, have access to the widest possible selection of health maintenance organizations, preferred provider organizations, and fee-for-service plans."

P. 7, lines 1-7. I think it would be clearer (and shorter) if the first sentence read: "The corporation shall rank the health benefit plans offered in one of 3 tiers based on quality and cost." The word "plan" is used with two different meanings in lines 1-3—first to refer to insurers (HMOs, PPOs, and fee-for-service plans) and then to refer to the "statewide plan" which I'm trying to eliminate from the draft.

The second sentence (lines 3-7) captures what I initially told you in our meeting, but in hindsight I don't think it would be prudent to put into law a reference to "average"

quality and "low quality." So I'd rewrite to read: "The corporation shall assign to tier 1 the health benefit plans that it determines provide high quality care at a low risk-adjusted cost, assign to tier 2 the health benefit plans that it determines provide car at a high cost, and assign to tier 3 the health benefit plans that it determines provide care at the highest cost."

P. 7, lines 12-19. As mentioned earlier, would it make sense to move this entire section to—and blend it with—the definition of "resident" on P. 4? The draft's current division of who's eligible for a Health Insurance Purchasing Account is in two parts—first the definition of "resident" on P. 4, and then the exclusion on P.7 of certain "residents" who don't qualify—is a bit confusing. Could we have one big section, located in the definition section, that gives all the rules for which people living in Wisconsin are *eligible residents* for purposes of having and using a Health Insurance Purchasing Account?

I also have two textual concerns about the exclusion of federal employees on lines 16-19. Could this language inadvertently be read to exclude people eligible for Medicaid or BadgerCare? They're "eligible for health care coverage...sponsored by the federal government," and that coverage is "related" to their employment. My intent would be better captured if this were to read "related to the individual's employment...in the U.S. armed forces etc." But there's a troubling "or" in between "employment" and "service" that suggests that the "employment" test need not be met only by being in the US armed forces.

The second textual concerns regarding these lines is whether we also want to exclude people who are employed by US agencies other than the armed service? Can Wisconsin legally impose an assessment on a federal agency of any sort, e.g., Department of Agriculture or Department of Housing and Urban Development? Do we need to exclude *all* people eligible for health care coverage from the federal government—regardless of whether it's Medicare, the federal employee health plan, or a military plan?

P. 7, lines 22. Delete reference to " under the statewide plan".

P. 7, lines 23-24. Replace with: "will be assigned randomly to a tier 1 plan". The Corporation doesn't have the resources to make individual-by-individual judgments about *which* tier 1 plan "provides the greatest accessibility to health care for the individual."

P. 8, Lines1-5. This is fine. But I want to make clear how Model #1 anticipates the age/sex risk adjustment process will work. First, the Corporation will assign to each Health Insurance Purchasing Account a fixed dollar amount that (a) has been adjusted for the age and sex of the resident who owns the Account and (b) is the amount that the Corporation will pay on the resident's behalf as the full monthly premium to all tier 1 plans available to the resident in his or her county. Second, after the resident chooses a plan—whether from tier 1, 2, or 3—the Corporation will move this pre-set dollar amount to the chosen plan. (If it's a tier 2 or 3 plan, of course, the resident pays the extra amount out of pocket.) In other words, the Corporation does its risk adjustment work *upfront*, at the time it knows the age and sex of the resident and then learns what will be paid to tier

1 plans. After that, the Corporation does no more risk adjustment (with the possible exception of making special payments to certain plans who, despite age and sex-based payments, ended up with more risk than they should have received). Based on this explanation, would it be appropriate to rewrite this risk assessment section as well as the one on P. 7, Lines 8-11?

P. 8, lines 5-18. References to "statewide plan" should be deleted.

P. 8, line 14-18. In line 15, delete "uninsured". The pharmacy benefit is insured—just not be insurance carriers.

This paragraph also needs to make reference to co-pays.

P. 8, Lines 19-25. Apart from the age/sex-adjusted dollar amounts in their Accounts, residents do *not* pay a monthly premium for tier 1 plans. Thus, the monthly premium paid for tier 2 plans can't be twice tier 1, since 0 x 2 = 0. And the ratio between the tiers is too rigid. The Corporation needs flexibility to set monthly out-of-pocket premiums for tiers 2 and 3 to reflect the approximate actual costs between tier 1 vs. tier 2, and tier 2 vs. tier 3. This section needs to be reworked. I suggest something like:

"For covered individuals who select a tier 1 plan, no out-of-pocket monthly premium shall be paid. The corporation shall determine the out-of-pocket monthly premium that covered individuals shall pay for tier 2 and tier 3 plans based upon the actual differences in costs between tier 1 and tier 2 plans, and between tier 2 and tier 3 plans."

P. 9, lines 1-2. Delete "high" in line 2. Also, again, eliminate reference to "statewide plan".

P. 9, Lines 3-7. This section is drafted correctly pursuant to our meeting. However, upon further reflection a provision needs to be added: an annual cap on the deductible and co-pays, i.e., what they total. My recommendation is: $2,000 per adult, and $1,000 per child.

I would also like to verify that the Corporation would have the authority to require *lower* co-pays for children and *lower* co-pays for low-income adults & children. I read the language on P. 9, Lines 3-7, as providing the Corporation with broad discretion in this area. Is this an accurate reading of this section?

P. 9, lines 12-17. As discussed earlier: DELETE to avoid ERISA complications.

P. 9, Lines 18-19. This should be deleted. It is preferable that employers *not* pay any part of Wisconsin residents' premiums under Sec. 260.20(1), i.e., the extra out-of-pocket amounts for tier 2 or tier 3 plans. And it would be better if employers also did *not* pay for any other cost sharing. While it is impossible to prevent employers from doing so, nothing is gained by explicitly permitting employers to pick up their employees' costs. Silence on this point is the better policy.

P. 10, line 13. My model assumes that:

- Enrollment would occur in 2006
- Coverage would first take place in 2007
- Payment to the Corporation would be settled up in 2008.

However, to get going quickly on tackling the many challenges that will be faced in making the Corporation and its Accounts a viable endeavor, I'd recommend that the effective date for everything be immediate, i.e., upon publication.

Reply to Questions Raised in Drafter's Note

Pam Kahler Questions:

#1. Yes, as discussed at the beginning of this memo, the draft should not make reference to a "Statewide Comprehensive Health Insurance Plan", but instead refer to Health Insurance Purchasing Accounts.

#2. Having the State of Wisconsin borrow money and lend it to the Corporation as needed is fine. I don't think there's a need to specify an interest rate. The idea is to obtain the lowest interest rate possible—which depends on market conditions—and pass that rate along to the Corporation.

The State should not provide any subsidy to the Corporation. D-note - need to authorize the State to lend \$ to Corp?

#3. Your ERISA concerns are valid. However, the language on P. 9, Lines 12-17, *increases* the risk of this initiative being invalidated under ERISA. Therefore, that language should be eliminated. **The proposal should make no reference at all to employers except with respect to the wage-based assessment, and should make *absolutely* no reference to employers' purchasing or provision of health insurance.**

Marc Shovers' Questions

I've already addressed Marc's first question about who—employee or employer—really pays the employer's 75% (minimum) of the assessment.

To answer your questions concerning the "reconciliation" between what a Wisconsin resident with a Health Insurance Purchasing Account owes and what has already been pre-paid on his/her behalf by his employer:

•The individual (i.e., neither DOR nor the Corporation) would initially calculate whether reconciliation is needed, and if so whether the individual owes more or is entitled to a refund.

•The individual would notify the Corporation of the outcome of this reconciliation, i.e., whether he/she owes money (if so, making payment with the form) or has a refund due.

• If a refund is due, the Corporation would pay the refund out of its revenues.

I think that covers it.

Kahler, Pam

From: Kreye, Joseph
Sent: Thursday, February 24, 2005 7:11 AM
To: Kahler, Pam
Subject: RE: Tax question

It is exempt, generally, from state income tax because the state adopts the federal tax provisions related to the 501 (c) (3) entities.

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

-----Original Message-----
From: Kahler, Pam
Sent: Wednesday, February 23, 2005 2:14 PM
To: Kreye, Joseph
Subject: Tax question

Joe:

I assume that if I make a corporation "exempt from federal taxation under section 501 (c) (3) of the Internal Revenue Code" it is also exempt from state tax without saying so, is that correct? If so, why is that? Thanks!

Pam

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–0950/P2
PJK&MES:jld:pg

rm is run

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

D-Note

creating the Health Insurance Purchasing Corporation of Wisconsin, establishing a health insurance purchasing arrangement through the use of private accounts for all state residents;

Reference

AN ACT ***to amend*** 71.06 (2m) and 71.64 (9) (b) (intro.); and ***to create*** 13.94 (1s) (c) 4., 20.505 (4) (fm), 71.06 (2c), 71.06 (2s) (e), 71.64 (1) (d) and chapter 260 of the statutes; **relating to:** ~~a statewide health insurance plan~~ and creating an individual income surtax.

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. 20.505 (4) (fm) of the statutes is created to read:

20.505 **(4)** (fm) ~~Health Care Comprehensive~~ *Health Insurance* ~~Plan of Wisconsin.~~

A sum sufficient equal to amounts collected under s. 71.06 (2c), to be paid to the

(1) purchasing accounts

Health Insurance Purchasing Corporation of Wisconsin for establishing, funding, ~~the operating and administrative costs of the Statewide Comprehensive Health Insurance Plan of Wisconsin~~ and assisting individuals with the use of their health insurance purchasing accounts under ch. 260

SECTION 3. 71.06 (2c) of the statutes is created to read:

71.06 **(2c)** INDIVIDUALS; AFTER 2005; INCOME SURTAX. The surtax to be assessed, levied, and collected upon the taxable incomes of all individuals shall be computed at the following rates:

(a) For taxable years beginning after December 31, 2005, for single individuals, heads of households, and married persons filing separately, on all taxable income from $0 to $70,000, 10 percent, except that the first $10,000 of taxable income shall be exempt from taxation under this subsection.

(b) For taxable years beginning after December 31, 2005, for married persons filing jointly, on all taxable income from $0 to $140,000, 10 percent, except that the first $20,000 of taxable income shall be exempt from taxation under this subsection.

SECTION 4. 71.06 (2m) of the statutes is amended to read:

71.06 **(2m)** RATE CHANGES. If a rate under sub. (1), (1m), (1n), (1p) ~~or~~, (2), or (2c) changes during a taxable year, the taxpayer shall compute the tax for that taxable year by the methods applicable to the federal income tax under section 15 of the internal revenue code.

SECTION 5. 71.06 (2s) (e) of the statutes is created to read:

71.06 **(2s)** (e) For taxable years beginning after December 31, 2005, with respect to nonresident individuals, including individuals changing their domicile into or from this state, the surtax brackets under sub. (2c) shall be multiplied by a fraction, the numerator of which is Wisconsin adjusted gross income and the denominator of which is federal adjusted gross income. In this paragraph, for

married persons filing separately "adjusted gross income" means the separate adjusted gross income of each spouse, and for married persons filing jointly "adjusted gross income" means the total adjusted gross income of both spouses. If an individual and that individual's spouse are not both domiciled in this state during the entire taxable year, the surtax brackets under sub. (2c) on a joint return shall be multiplied by a fraction, the numerator of which is their joint Wisconsin adjusted gross income and the denominator of which is their joint federal adjusted gross income.

SECTION 6. 71.64 (1) (d) of the statutes is created to read:

71.64 **(1)** (d) Of the amounts withheld in accordance with tables to be prepared by the department under sub. (9) that relate to the surtax under s. 71.06 (2c), the employer is responsible for funding at least 75 percent of the amount that must be withheld, and the employee is responsible for funding the remaining amount that must be withheld.

SECTION 7. 71.64 (9) (b) (intro.) of the statutes is amended to read:

71.64 **(9)** (b) (intro.) The department shall from time to time adjust the withholding tables to reflect any changes in income tax rates, any applicable surtax or any changes in dollar amounts in s. 71.06 (1), (1m), (1n), (1p) ~~and~~, (2), and (2c) resulting from statutory changes, except as follows:

SECTION 8. Chapter 260 of the statutes is created to read:

Purchasing Accounts

CHAPTER 260

~~STATEWIDE COMPREHENSIVE~~ HEALTH INSURANCE ~~PLAN OF WISCONSIN~~

260.01 Definitions. In this chapter:

(1) "Brand name" has the meaning given in s. 450.12 (1) (a).

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

(3) "Generic name" has the meaning given in s. 450.12 (1) (b).

(4) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months, except that, if a child is under 6 months of age, the child is a "resident" if the child lives in this state and at least one of the child's parents or the child's guardian has been legally domiciled in this state. For purposes of this chapter, legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return.

****NOTE: This definition is based on the one used in HIRSP [s. 149.10 (9)] for the definition of "resident," but I changed "30 days" to "6 months." You wanted to use the same definition that is used for income tax purposes, but there is none. The tax statutes refer to a resident as a person who is domiciled in the state for the entire year.

(5) "Statewide plan" means the Statewide Comprehensive Health Insurance Plan of Wisconsin.

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

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

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

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

2. That the corporate board shall consist of ~~11~~ 8 directors ~~including at least 5 representatives of employers and at least 5 representatives of employees~~.

****NOTE: You indicated that you wanted the board of directors to have the same number and makeup as the Council on Worker's Compensation. That council has a designated employee of DWD as chairperson, 5 employer members, 5 employee members, and 3 nonvoting members that represent insurers authorized to do worker's compensation business. A council, however, is attached to a state agency, unlike a private corporation. Do you want to make any changes to the directors in this draft?

****NOTE: Do you want to specify the length of the terms of the directors? If it is not specified, it is one year [see s. 181.0805 (1)]

Insert 5-1

(c) Designate the initial directors as specified in par. (b) 2.

(d) Draft bylaws for adoption by the corporate board.

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

****NOTE: The funds referred to are the GPR funds attributable to the amounts withheld from employee wages and salaries and contributed by employers.

Insert 5-5

(a) Develop and administer the statewide plan as provided in this chapter.

Insert 5-6

(b) ~~Seek~~ to obtain federal funds for paying costs related to ~~individuals covered under the statewide plan~~ who would otherwise be eligible for coverage under Medical Assistance, the Badger Care health care program, or any other health care program financed at least in part with federal funds.

eligible residents

health insurance purchasing accounts

(c) Expend in a state fiscal year in costs to administer the ~~statewide plan~~ not more than one percent of the amount appropriated under s. 20.505 (4) (fm) for that state fiscal year.

(d) Keep its records open at all times to inspection and examination by the governor or any committee of either or both houses of the legislature.

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

(f) Cooperate with the legislative audit bureau in the performance of the audits under sub. (3).

Insert 5-18

health insurance purchasing arrangement under this chapter

(3) BIENNIAL AUDIT. Biennially, the legislative audit bureau shall conduct a financial audit of the corporation and a performance evaluation audit of the ~~statewide plan~~ that includes an audit of the corporation's policies and management practices. The legislative audit bureau shall distribute a copy of each audit report under this subsection to the legislature under s. 13.172 (2) and to the governor. The corporation shall reimburse the legislative audit bureau for the cost of the audits and reports required under this subsection.

****NOTE: Do you want both financial and performance evaluation audits as drafted, or just one of those?

****NOTE: A rec t bureau of a private corporation is highly unusual. Perhaps it w authorize the secretary of administration, or another state office audits.

insert 6-8

new staff replaces part of p. 6, all of pp. 7+8, and most of p. 9

260.10 General dministration. (1) STATEWIDE PLAN DESCRIPTION. The statev der this chapter shall be known as the "Statewide Comprehens nce Plan of Wisconsin." Except as provided in s. 260.18 (2), vided under the statewide plan through private group health benefit plans offered by insurers. The statewide plan and any health benefit plan under which coverage is provided under the statewide plan are subject to all applicable provisions of chs. 600 to 646.

(2) PARTICIPATION OF INSURERS. (a) The corporation shall solicit bids from, and enter into contracts with, insurers for providing coverage ~~under the statewide plan~~. Any insurer that is authorized to do business in this state in one or more lines of insurance that includes health insurance shall be eligible to participate.

(b) The corporation shall ~~attempt~~ seek to ensure that ~~sufficient number of~~ fee–for–service plans, health maintenance organizations, and preferred provider plans are included in the statewide plan so that covered individuals have adequate choice among plan types and adequate accessibility to health care.

insert 6-22

(c) SELECTION → to eligible residents

submit a bid

eligible residents have access to the widest possible selection of

(3) TIER ASSIGNMENT. The corporation shall rank each health benefit plan offered by an insurer participating in the plan and assign the plan to one of 3 tiers based on quality and cost. The corporation shall assign health benefit plans that it determines provide high quality at a low cost to "Tier 1," assign health benefit plans that it determines provide average quality at average cost to "Tier 2," and assign health benefit plans that it determines provide relatively low quality at relatively high cost to "Tier 3."

(4) RISK–ADJUSTED PAYMENTS. Payments made to a health benefit plan for coverage of an individual who selects, or is assigned to, the health benefit plan under s. 260.15 (2) shall be adjusted for the individual's risk, as determined under s. 260.15 (3).

260.15 Covered individuals. (1) WHO IS COVERED. (a) Except as provided in par. (b), every resident shall be covered under the statewide plan.

(b) None of the following is eligible for coverage under the statewide plan:

1. An individual who 65 years of age or older.

2. An individual who is eligible for health care coverage that is provided or sponsored by the federal government or an agency of the federal government and that is related to the individual's employment or service in the U.S. armed forces or in forces incorporated as part of the U.S. armed forces.

(2) HEALTH BENEFIT PLAN SELECTION. During an annual open enrollment period, each covered individual shall select from among the health benefit plans offered under the statewide plan. If an individual does not make a selection, the individual will be assigned to the least costly health benefit plan that provides the greatest accessibility to health care for the individual.

(3) RISK ASSESSMENT. The demographic, actuarially based characteristics of each covered individual, such as age and sex, shall be assessed and used to determine the individual's risk for the purpose of making the risk–adjusted payments under s. 260.10 (4).

260.18 Benefits. (1) BASIC HEALTH CARE BENEFITS. Each health benefit plan offered under the statewide plan shall provide the same benefits, including all of the following:

(a) Except as provided in par. (b), coverage of basic, comprehensive health care services, including physicians' services and inpatient hospital services, which shall be subject to copayments.

(b) Coverage of cost–effective, preventive services or procedures, such as childhood immunizations, physical examinations, and Papanicolaou tests, which shall be determined by the corporation and for which no copayments may be imposed.

(2) PHARMACY BENEFIT. Separate from the health benefit plans offered by insurers under the statewide plan, the statewide plan corporation shall provide an uninsured a pharmacy benefit that uses a preferred list of covered prescription drugs. The corporation shall develop the preferred list of covered prescription drugs under an evidence–based analysis similar to the method used under s. 40.53 (2).

260.20 Cost sharing. (1) PREMIUMS. Insert 8-19 Every covered individual shall pay a monthly premium for coverage under the statewide plan, based on the tier to which the individual's health benefit plan is assigned under s. 260.10 (3). The corporation shall determine the premium rates in such a way that the premium for a health benefit plan assigned to "Tier 2" is twice as much as the premium for a health benefit plan assigned to "Tier 1," and the premium for a health benefit plan assigned to "Tier 3" is twice as much as the premium for a health benefit plan assigned to "Tier 2."

and that requires the copayments under s. 260.20(3)

(2) DEDUCTIBLES. Each health benefit plan offered under the statewide plan shall include a high deductible, which shall be determined by the corporation.

****NOTE: Is the deductible the same for every plan?

(3) COPAYMENTS. (a) Except as provided in s. 260.18 (1) (b), every health benefit plan offered under the statewide plan shall require a copayment for every covered benefit. The corporation shall determine the amounts of the copayments, and shall require a higher copayment for the inappropriate use of a benefit, such as obtaining emergency services for treatment of a nonemergency condition.

(b) The statewide plan shall require a copayment of $5 for each prescription of a drug with a generic name, a copayment of $15 for each prescription of a drug with a brand name and that is on the preferred list, and a copayment of $35 for each prescription of a drug with a brand name and that is not on the preferred list.

260.25 Supplemental and employer-provided benefits. (1) SUPPLEMENTAL HEALTH CARE BENEFITS. Nothing in this chapter prevents an individual from procuring insurance providing any supplemental health care benefits not provided under the statewide plan, or an employer from providing for the employer's employees, by insurance or otherwise, any supplemental health care benefits not provided under the statewide plan.

(2) EMPLOYER–PAID COST SHARING. Nothing in this chapter prevents an employer from paying all or part of any employee cost sharing under s. 260.20.

****NOTE: Do you want to authorize employers to pay some or all of its employees' cost sharing as in this subsection?

SECTION 9. Nonstatutory provisions.

(1) WAIVERS. The department of health and family services shall request waivers from the secretary of the federal department of health and human services for all of the following purposes:

SECTION 9

(a) To allow the use of federal financial participation to fund, to the maximum extent possible, the ~~benefits provided under the Statewide Comprehensive Health Insurance Plan of Wisconsin to individuals~~ who are eligible to receive health care benefits under Medical Assistance or the Badger Care health care program or any other assistance related to health care benefits that is financed at least in part with federal funds.

(b) To allow ~~individuals~~ who are eligible for coverage under Medical Assistance or the Badger Care health care program, or under any other assistance program ~~that provides health care~~ and that is financed at least in part with federal funds, to be covered under the Statewide Comprehensive Health Insurance Plan of Wisconsin and to receive the benefits, including the pharmacy benefit, provided under the Statewide Comprehensive Health Insurance Plan of Wisconsin.

****NOTE: This version of the draft does not include an initial applicability or effective date provision.

(END)

health insurance purchasing accounts of eligible residents, as defined in section 260.01 (2) of the statutes, as created by this act, Insert 10-9

eligible residents, as defined in section 260.01 (2) of the statutes, as created by this act,

INSERT 4–4

satisfies all of the following criteria:

(a) The individual

(END OF INSERT 4–4)

INSERT 4–12

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

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

(3) "Tier 1 plan" means a health benefit plan that has been assigned to "Tier 1" under s. 260.10 (2).

(4) "Tier 2 plan" means a health benefit plan that has been assigned to "Tier 2" under s. 260.10 (2).

(5) "Tier 3 plan" means a health benefit plan that has been assigned to "Tier 3" under s. 260.10 (2).

(END OF INSERT 4–12)

INSERT 4–22

who, except for the initial directors, shall be designated or appointed as follows:

a. One designated by the head of Wisconsin Manufacturers and Commerce.

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

c. One designated by the head of the Metro Milwaukee Association of Commerce.

ins 4-22 cont'd

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

e. Two nominated by the governor and appointed with the advice and consent of the senate.

(END OF INSERT 4–22)

INSERT 4–23

3. That the term of a director shall be 6 years, except that the term of an initial director shall be one year.

4. The names and addresses of the initial directors.

(END OF INSERT 4–23)

INSERT 5–1

With the advice of the individuals charged with designating or nominating the directors under par. (b) 2. a. to e.,

(END OF INSERT 5–1)

INSERT 5–5

(a) Establish and fund health insurance purchasing accounts in the manner provided in this chapter and assist eligible residents in using their accounts to purchase health care coverage.

(END OF INSERT 5–5)

INSERT 5–6

Cooperate with the department of health and family services in seeking

(END OF INSERT 5–6)

INSERT 5–18

ins 5-18

(g) Submit on each October 1 an annual report to the governor and to the legislature under s. 13.172 (2) regarding its activities.

(END OF INSERT 5–18)

INSERT 9–20 ins 4

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

(b) The corporation shall seek to ensure that eligible residents have access to the widest possible selection of fee–for–service plans, health maintenance organizations, and preferred provider plans.

(2) TIER ASSIGNMENT. The corporation shall rank the health benefit plans offered by the insurers with which the corporation contracts under sub. (1) and assign each health benefit plan to one of 3 tiers based on quality and cost. The corporation shall assign to "Tier 1" health benefit plans that it determines provide high quality care at a low risk–adjusted cost, assign to "Tier 2" health benefit plans that it determines provide care at a higher risk–adjusted cost, and assign to "Tier 3" health benefit plans that it determines provide care at the highest risk–adjusted cost.

(3) PLAN SELECTION. During an annual open enrollment period, each eligible resident shall select from among the health benefit plans offered. An individual who does not make a selection will be assigned to a Tier 1 plan.

ins 9-20 cont 20 04

(4) PREMIUM DETERMINATION AND RISK–ADJUSTMENT. (a) The corporation shall determine the monthly premium amounts for coverage under each plan, with Tier 1 plans having the lowest premiums, Tier 2 plans having higher premiums than Tier 1 plans, and Tier 3 plans having higher premiums than Tier 2 plans. The premium diferences shall be based on the actual differences in costs between Tier 1 plans and Tier 2 plans, and between Tier 2 plans and Tier 3 plans.

(b) Each premium amount determined under par. (a) shall be adjusted for each eligible resident who has selected the health benefit plan under sub. (3), to account for the eligible resident's risk, based on his or her age and sex.

260.15 Health insurance purchasing accounts. (1) ESTABLISHMENT AND FUNDING. The corporation shall establish for each eligible resident a private account and shall credit to the account the dollar amount of the full premium, risk–adjusted for the eligible resident as provided in s. 260.10 (4) (b), for a Tier 1 plan in the county in which the eligible resident resides.

(2) PREMIUM PAYMENT. The corporation shall pay the amount in each eligible resident's account to the health benefit plan selected by the eligible resident as part or all of the risk–adjusted premium for coverage under the health benefit plan.

260.25 Benefits. (1) BASIC HEALTH CARE BENEFITS. Each health benefit plan shall provide the same benefits, including all of the following:

(a) Coverage of basic, comprehensive health care services, including physicians' services and inpatient hospital services.

(b) Coverage of certain specific cost–effective, preventive services or procedures determined by the corporation, such as childhood immunizations, physical examinations, and Papanicolaou tests, for which no copayments may be imposed.

↓

lns 9-20 cont'd 3894

(2) PHARMACY BENEFIT. Separate from the health benefit plans offered by insurers, the corporation shall provide a pharmacy benefit that uses a preferred list of covered prescription drugs. The corporation shall develop the preferred list of covered prescription drugs under an evidence–based analysis similar to the method used under s. 40.53 (2).

260.30 Cost sharing. (1) PREMIUMS. (a) An eligible resident with coverage under a Tier 1 plan shall pay no premium in addition to the amount paid by the corporation under s. 260.15 (2).

(b) An eligible resident with coverage under a Tier 2 plan or Tier 3 plan shall be required to pay the amount by which the full risk–adjusted premium for the health benefit plan selected by the eligible resident exceeds the amount paid by the corporation under s. 260.15 (2).

(2) DEDUCTIBLES AND COPAYMENTS. (a) Every health benefit plan shall include a deductible, which shall be determined by the corporation.

(b) Except as provided in s. 260.25 (1) (b), every health benefit plan shall require a copayment for every covered benefit. The corporation shall determine the amounts of the copayments, and shall require a higher copayment for the inappropriate use of a benefit, such as obtaining emergency services for treatment of a nonemergency condition.

(c) An eligible resident who is an adult may not be required to pay more than $2,000 annually in deductible and copayments under this subsection. An eligible resident who is a child may not be required to pay more than $1,000 annually in deductible and copayments under this subsection.

(3) PHARMACY BENEFIT COPAYMENTS. The corporation shall require a copayment of $5 for each prescription of a generic drug, a copayment of $15 for each prescription

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of a brand name drug that is on the preferred list, and a copayment of $35 for each prescription of a brand name drug that is not on the preferred list.

****NOTE: I wasn't sure if the drug copayments were separate from the annual cap on the deductibles and copayments for other health care benefits. This is drafted as if they are.

****NOTE: Do you want to specify that deductibles and copayments for MA and BadgerCare–eligible persons are less than for other persons? Perhaps just the cap can be lowered?

(END OF INSERT 9–20)

INSERT 10–9

may purchase health care coverage through the use of health insurance purchasing accounts and to receive health care benefits, including the pharmacy benefit, under the arrangement established under chapter 260 of the statutes, as created by this act.

(END OF INSERT 10–9)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0950/P2dn
PJK&MES:jld:pg

1. According to my reading of the relevant provisions of ch. 181, ch. 181 does not provide for the initial directors to be appointed in the manner that you envision. For that reason, I provided for the secretary of administration to designate the initial directors, for a term of one year, upon the advice of the individuals who designate the directors who serve six-year terms.

2. Concerning your redraft instructions related to MA, I do not know what you mean by the "family" portion of MA. I also do not understand why the corporation would pay DHFS $400,000,000-$500,000,000 until the waivers are approved. Where does this money come from? I assume that MA-eligible people will not be incorporated into the private account scheme before any waivers are approved and that before that time MA costs would be paid as they are now (with general purpose revenue and federal financial participation), so why would the corporation pay DHFS anything? If MA-eligible people *are* incorporated before waivers are approved, I assume the state would lose any federal financial participation, so the cost of the private account scheme would be higher, but why would anything be paid to DHFS? I have not made any changes to the nonstatutory provisions that require DHFS to request waivers related to covering individuals who are eligible for MA.

3. Proposed s. 260.05 (2) (c) does not require the corporation to have the same fiscal year as the state. I used "state fiscal year" because that is how the appropriation amounts are accounted for and shown in the schedule. If the corporation is prohibited from spending for administrative costs more than one percent of an amount, there must be some way of determining and identifying the amount.

4. You questioned whether the corporation needed to be made exempt from state income tax. According to Joe Kreye, who drafts corporate income tax provisions, if a corporation is exempt from federal income tax under section 501 (c) (3) of the IRC, it is also exempt from state income tax because the state adopts the federal tax provisions related to 501 (c) (3) entities.

5. This draft still does not treat provisions in current law that will be affected, such as the state employee health care provisions. Although you want the bill to be immediately effective, that may not work for all of the other treatments that the bill will eventually include.

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