State of Wisconsin
1997 - 1998 LEGISLATURE

LRBb2347/1
PJK:kmg:ijs

ASSEMBLY AMENDMENT 8,
TO ASSEMBLY AMENDMENT 8,
TO ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 1997 ASSEMBLY BILL 100

September 16, 1997 – Offered by Representatives LORGE and BAUMGART.

At the locations indicated, amend the amendment as follows:

1. Page 37, line 15: after that line insert:

"116c. Page 101, line 3: increase the dollar amount for fiscal year 1997–98 by $435,600 and increase the dollar amount for fiscal year 1998–99 by $780,800 to increase funding for the purposes for which the appropriation is made.

116e. Page 101, line 3: after that line insert:

"(af) Plan costs GPR A 6,000,000 11,900,000".

116g. Page 101, line 9: increase the dollar amount for fiscal year 1997–98 by $47,300 and increase the dollar amount for fiscal year 1998–99 by $94,600 to increase funding for the purposes for which the appropriation is made.".

2. Page 52, line 6: after that line insert:

"232c. Page 179, line 1: delete lines 1 and 2.".

3. Page 52, line 20: before that line insert:

"236c. Page 183, line 2: delete lines 2 to 5.".

4. Page 53, line 12: delete lines 12 to 14.

5. Page 64, line 1: after that line insert:

"346c. Page 269, line 22: delete the material beginning with that line and ending with page 270, line 4, and substitute:

"**SECTION 211m.** 20.145 (7) (af) of the statutes is created to read:

20.145 **(7)** (af) *Plan costs.* The amounts in the schedule for paying a portion of the operating costs of the health insurance risk–sharing plan under subch. II of ch. 619.".

346e. Page 270, line 6: delete lines 6 to 11 and substitute:

"**SECTION 213hm.** 20.145 (7) (g) of the statutes is amended to read:

20.145 **(7)** (g) *Premium and deductible reduction subsidy; insurer assessments and penalties.* All moneys received from insurer assessments and penalties under s. 619.135 and under 1997 Wisconsin Act .... (this act), section 9127 (5xt), for subsidizing premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).".".

6. Page 74, line 16: after that line insert:

"401c. Page 356, line 3: delete lines 3 to 6.".

7. Page 74, line 23: delete the material beginning with that line and ending with page 75, line 3.

8. Page 218, line 19: after that line insert:

"808c. Page 1051, line 15: delete lines 15 to 19.".

9. Page 326, line 7: delete the material beginning with that line and ending with page 331, line 8, and substitute:

"1083c. Page 1353, line 7: delete the material beginning with that line and ending with page 1358, line 11.".

10. Page 348, line 5: delete "~~ch.~~ chs. 149 and" and substitute "ch.".

11. Page 348, line 20: delete "~~, subch. II of ch. 619~~" and substitute ", subch. II of ch. 619".

12. Page 440, line 9: after that line insert:

"1347c. Page 1799, line 3: delete lines 3 to 13.".

13. Page 440, line 11: after that line insert:

"1348c. Page 1799, line 15: delete the material beginning with that line and ending with page 1800, line 18.".

14. Page 440, line 22: delete the material beginning with that line and ending with page 443, line 20, and substitute:

"1352c. Page 1801, line 4: delete the material beginning with that line and ending with page 1825, line 21, and substitute:

"**SECTION 4816d.** 619.10 (1m) of the statutes is repealed.

SECTION 4817d. 619.10 (2c) of the statutes is created to read:

619.10 **(2c)** "Church plan" has the meaning given in section 3 (33) of the federal Employee Retirement Income Security Act of 1974.

SECTION 4817e. 619.10 (2j) of the statutes is created to read:

619.10 **(2j)** (a) Except as provided in par. (b), "creditable coverage" means coverage under any of the following:

1. A group health plan.

2. Health insurance.

3. Part A or part B of title XVIII of the federal Social Security Act.

4. Title XIX of the federal Social Security Act, except for coverage consisting solely of benefits under section 1928 of that act.

5. Chapter 55 of title 10 of the United States Code.

6. A medical care program of the federal Indian health service or of an American Indian tribal organization.

7. A state health benefits risk pool.

8. A health plan offered under chapter 89 of title 5 of the United States Code.

9. A public health plan.

10. A health coverage plan under section 5 (e) of the federal Peace Corps Act, 22 USC 2504 (e).

(b) "Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in section 2791 (c) of P.L. 104–191.

SECTION 4817g. 619.10 (2t) of the statutes is created to read:

619.10 **(2t)** "Eligible individual" means an individual for whom all of the following apply:

(a) The aggregate of the individual's periods of creditable coverage is 18 months or more.

(b) The individual's most recent period of creditable coverage was under a group health plan, governmental plan, federal governmental plan or church plan, or under any health insurance offered in connection with any of those plans.

(c) The individual does not have creditable coverage and is not eligible for coverage under a group health plan, part A or part B of title XVIII of the federal Social

Security Act or a state plan under title XIX of the federal Social Security Act or any successor program.

(d) The individual's most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or a failure to pay premiums.

(e) If the individual was offered the option of continuation coverage under a federal continuation provision or similar state program, the individual elected the continuation coverage.

(f) The individual has exhausted any continuation coverage under par. (e).

SECTION 4818c. 619.10 (3c) of the statutes is created to read:

619.10 **(3c)** "Federal continuation provision" means any of the following:

(a) Section 4980B of the Internal Revenue Code of 1986, except for section 4980B (f) (1) of that code insofar as it relates to pediatric vaccines.

(b) Part 6 of subtitle B of title I of the federal Employee Retirement Income Security Act of 1974, except for section 609 of that act.

(c) Title XXII of P.L. 104–191.

SECTION 4818f. 619.10 (3d) of the statutes is created to read:

619.10 **(3d)** "Federal governmental plan" means a benefit program established or maintained for its employes by the government of the United States or by any agency or instrumentality of the government of the United States.

SECTION 4818j. 619.10 (3g) of the statutes is created to read:

619.10 **(3g)** "Governmental plan" has the meaning given under section 3 (32) of the federal Employee Retirement Income Security Act of 1974.

SECTION 4818m. 619.10 (3j) of the statutes is created to read:

619.10 **(3j)** "Group health plan" means any of the following:

(a) An employe welfare plan, as defined in section 3 (1) of the federal Employee Retirement Security Act of 1974, to the extent that the employe welfare plan provides medical care, including items and services paid for as medical care, to employes or to their dependents, as defined under the terms of the employe welfare plan, directly or through insurance, reimbursement or otherwise.

(b) Any program that would not otherwise be an employe welfare benefit plan and that is established or maintained by a partnership, to the extent that the program provides medical care, including items and services paid for as medical care, to present or former partners of the partnership or to their dependents, as defined under the terms of the program, directly or through insurance, reimbursement or otherwise.

SECTION 4823m. 619.10 (8j) of the statutes is created to read:

619.10 **(8j)** "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition of an individual that existed before the individual's date of enrollment for coverage, whether or not the individual received any medical advice or recommendation, diagnosis, care or treatment related to the condition before that date.

SECTION 4824p. 619.10 (9) of the statutes is amended to read:

619.10 **(9)** "Resident" means a person who has been legally domiciled in this state for a period of at least 30 days or, with respect to an eligible individual, an individual who resides in this state. For purposes of this subchapter, 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. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this

state. A person with a developmental disability or another disability which prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state for 30 days.

SECTION 4825g. 619.115 of the statutes is created to read:

619.115 Rules relating to creditable coverage. The commissioner shall promulgate rules that specify how creditable coverage is to be aggregated for purposes of s. 619.10 (2t) (a) and that determine the creditable coverage to which s. 619.10 (2t) (b) and (d) applies. The rules shall comply with section 2701 (c) of P.L. 104–191.

SECTION 4827f. 619.12 (1) (intro.) of the statutes is amended to read:

619.12 **(1)** (intro.) Except as provided in subs. (1m) and (2), the board or administering carrier shall certify as eligible a person who is covered by medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has tested positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, a person who is an eligible individual, and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

SECTION 4830hm. 619.12 (2) (b) 2. of the statutes is amended to read:

619.12 **(2)** (b) 2. Subdivision 1. does not apply to any person who is an eligible individual or to any person who terminates coverage under the plan because he or she is receiving, or is eligible to receive, medical assistance benefits.

SECTION 4830im. 619.12 (2) (c) of the statutes is amended to read:

619.12 **(2)** (c) No person on whose behalf the plan has paid out ~~$500,000~~ $1,000,000 or more is eligible for coverage under the plan.

SECTION 4830jm. 619.12 (2) (d) of the statutes is amended to read:

619.12 **(2)** (d) ~~No~~ Except for a person who is an eligible individual, no person who is 65 years of age or older is eligible for coverage under the plan.

SECTION 4830km. 619.12 (2) (e) of the statutes, as affected by 1997 Wisconsin Act .... (this act), is amended to read:

619.12 **(2)** (e) No person who is eligible for ~~health care benefits~~ creditable coverage, other than those benefits specified in s. 632.745 (11) (b) 1. to 12., that ~~are~~ is provided by an employer on a self–insured basis or through health insurance is eligible for coverage under the plan.

SECTION 4830kr. 619.12 (2) (e) 1. of the statutes is renumbered 619.12 (2) (e) and amended to read:

619.12 **(2)** (e) ~~Except as provided in subd. 2., no~~ No person who is eligible for health care benefits, other than those benefits specified in s. 632.745 (11) (b) 1. to 12., that are provided by an employer on a self–insured basis or through health insurance is eligible for coverage under the plan.

SECTION 4830Lm. 619.12 (2) (e) 2. of the statutes is repealed.

SECTION 4830mm. 619.12 (2) (e) 3. of the statutes is repealed.

SECTION 4830r. 619.12 (2) (f) of the statutes is created to read:

619.12 **(2)** (f) No person who is eligible for medical assistance is eligible for coverage under the plan.

SECTION 4831nm. 619.12 (3) (a) of the statutes is amended to read:

619.12 **(3)** (a) Except as provided in pars. (b) ~~and~~ to (c), no person is eligible for coverage under the plan for whom a premium, deductible or coinsurance amount is

paid or reimbursed by a federal, state, county or municipal government or agency as of the first day of any term for which a premium amount is paid or reimbursed and as of the day after the last day of any term during which a deductible or coinsurance amount is paid or reimbursed.

SECTION 4831pm. 619.12 (3) (bm) of the statutes is created to read:

619.12 **(3)** (bm) Persons for whom premium costs for health insurance coverage are subsidized under s. 252.16 are not ineligible for coverage under the plan by reason of such payments.

SECTION 4831rm. 619.123 of the statutes is repealed.

SECTION 4835m. 619.13 (1) (a) of the statutes is renumbered 619.13 (1) and amended to read:

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

SECTION 4836m. 619.13 (1) (b) of the statutes is renumbered 619.13 (2) and amended to read:

619.13 **(2)** ~~Except as provided by a rule promulgated under s. 619.145 (4), every~~ Every participating insurer shall share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the insurer's total health care coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year, as determined by the commissioner.

SECTION 4837m. 619.13 (1) (c) of the statutes is repealed.

SECTION 4838m. 619.13 (1) (d) of the statutes is renumbered 619.13 (3), and 619.13 (3) (a), as renumbered, is amended to read:

619.13 **(3)** (a) Each insurer's proportion of participation under ~~par. (b)~~ sub. (2) shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner. The commissioner shall assess an insurer for the insurer's proportion of participation based on the total assessments estimated under s. 619.143 (2) (a) 2.

SECTION 4839cm. 619.13 (2) of the statutes is repealed.

SECTION 4845cm. 619.135 (2) of the statutes is renumbered 619.144 and amended to read:

619.144 (title) **Insurer assessments and provider discounts for premium and deductible reductions.** If the moneys under s. 20.145 (7) (a) and (g) are insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), or the commissioner determines that the moneys under s. 20.145 (7) (a) and (g) will be insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), the commissioner shall, by rule, increase in equal proportions the amount of the assessment ~~under sub. (1) (a) or levy an assessment against every insurer, or a combination of both,~~ set under s. 619.143 (2) (a) 2. and the provider charges discount rate set under s. 619.143 (2) (a) 3., subject to s. 619.143 (1) (b) 1., sufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).

SECTION 4846cm. 619.135 (3) of the statutes is amended to read:

619.135 **(3)** In addition to the assessments under ~~subs. (1) (a) and (2)~~ sub. (1), the commissioner may, by rule, establish an assessment to be levied against each

insurer that issues a notice of rejection under s. 619.12 (1) (a) to a person who becomes eligible for and obtains coverage under the plan as a result of receiving the notice. Any assessments levied and collected under this subsection shall be credited to the appropriation under s. 20.145 (7) (g).

SECTION 4849cm. 619.14 (2) (a) of the statutes is amended to read:

619.14 **(2)** (a) The plan shall provide every eligible person who is not eligible for medicare with major medical expense coverage. Major medical expense coverage offered under the plan under this section shall pay an eligible person's covered expenses, subject to sub. (3) and deductible and coinsurance payments authorized under sub. (5), up to a lifetime limit of ~~$500,000~~ $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.

SECTION 4849fm. 619.14 (3) (intro.) of the statutes is amended to read:

619.14 **(3)** COVERED EXPENSES. (intro.) Except as restricted by cost containment provisions under s. 619.17 (4) and except as reduced by the board under s. 619.15 (3) (e) or by the commissioner under s. 619.143 (2) (a) 3. or (3) or 619.144, covered expenses for the coverage under this section shall be the usual and customary charges for the services provided by persons licensed under ch. 446. Except as restricted by cost containment provisions under s. 619.17 (4) and except as reduced by the board under s. 619.15 (3) (e) or by the commissioner under s. 619.143 (2) (a) 3. or (3) or 619.144, covered expenses for the coverage under this section shall also be the usual and customary charges for the following services and articles when prescribed by a physician licensed under ch. 448 or in another state:

SECTION 4850cm. 619.14 (4) (intro.) of the statutes is amended to read:

619.14 **(4)** EXCLUSIONS. (intro.) Covered expenses for the coverage under this section shall not include the following:

SECTION 4850dh. 619.14 (4) (a) of the statutes is amended to read:

619.14 **(4)** (a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect. Breast reconstruction incident to a mastectomy shall not be considered treatment for cosmetic purposes.

SECTION 4850fm. 619.14 (4m) of the statutes is created to read:

619.14 **(4m)** DISCOUNTED PAYMENT IS PAYMENT IN FULL. A provider of a covered service or article shall accept as payment in full for the covered service or article the discounted reimbursement rate determined under ss. 619.143 (2) (a) 3. and (3), 619.144 and 619.15 (3) (e) and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under s. 619.143 (2) (a) 3. or (3), 619.144 or 619.15 (3) (e).

SECTION 4850hm. 619.14 (5) (title) of the statutes is amended to read:

619.14 **(5)** (title) ~~PREMIUMS, DEDUCTIBLES~~ DEDUCTIBLES AND COINSURANCE.

SECTION 4850mm. 619.14 (5) (a) of the statutes is amended to read:

619.14 **(5)** (a) The plan shall offer a deductible in combination with appropriate premiums determined under this subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. 619.165. For eligible persons under s. 619.165 (1) (b) 1., the deductible shall be $500. For eligible persons under s. 619.165 (1) (b) 2., the

deductible shall be $600. For eligible persons under s. 619.165 (1) (b) 3., the deductible shall be $700. For eligible persons under s. 619.165 (1) (b) 4., the deductible shall be $800. For all other eligible persons who are not eligible for medicare, the deductible shall be $1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year. ~~The schedule of premiums shall be promulgated by rule by the commissioner. The commissioner shall set rates at 60% of the operating and administrative costs of the plan.~~

SECTION 4853cm. 619.14 (5) (d) of the statutes is amended to read:

619.14 **(5)** (d) Notwithstanding pars. (a) to (c), the board may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the commissioner under s. 619.17 (4) (a) ~~and for individuals who enroll in an alternative plan under s. 619.145~~.

SECTION 4854mm. 619.14 (5) (e) of the statutes is repealed.

SECTION 4855mm. 619.14 (6) of the statutes is renumbered 619.14 (6) (a) and amended to read:

619.14 **(6)** (a) ~~No~~ Except as provided in par. (b), no person who obtains coverage under the plan may be covered for any preexisting condition during the first 6 months of coverage under the plan if the person was diagnosed or treated for that condition during the 6 months immediately preceding the filing of an application with the plan.

SECTION 4856mm. 619.14 (6) (b) of the statutes is created to read:

619.14 **(6)** (b) An eligible individual who obtains coverage under the plan may not be subject to any preexisting condition exclusion under the plan.

SECTION 4857d. 619.143 of the statutes is created to read:

619.143 Payment of plan costs. (1) The operating, administrative and subsidy costs of the plan shall be paid as follows:

(a) First from the appropriation under s. 20.145 (7) (af).

(b) The remainder of the costs as follows:

1. A total of 60% from all of the following:

a. The appropriations under s. 20.145 (7) (a) and (g).

b. Insurer assessments and provider reimbursement discounts under s. 619.144.

c. Subject to sub. (2) (a) 1. and s. 619.146 (2) (b), premiums collected from eligible persons.

2. A total of 40% as follows:

a. Fifty percent from insurer assessments, excluding assessments under s. 619.144 and moneys in the appropriation account under s. 20.145 (7) (g).

b. Fifty percent from discounts to provider reimbursement rates, excluding discounts under ss. 619.144 and 619.15 (3) (e).

(2) (a) Prior to each plan year, the commissioner, in consultation with the board, shall estimate the operating, administrative and subsidy costs of the plan for the new plan year and, taking into consideration the funds expected to be available under s. 20.145 (7) (a), (af) and (g), do all of the following:

1. By rule set premium rates for the new plan year, including the rates under s. 619.146 (2) (b), by estimating the rates necessary to equal the amount specified in sub. (1) (b) 1. c., except that a rate for coverage under s. 619.14 may not be less than

135% nor more than 190% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

2. By rule set the total insurer assessments under s. 619.13 for the new plan year by estimating the amount necessary to equal the amount specified in sub. (1) (b) 2. a.

3. By the same rule as required under subd. 2. set the rate at which provider charges shall be discounted for the new plan year by estimating the rate necessary to equal the amount specified in sub. (1) (b) 2. b.

(b) In setting the rates under par. (a) 1. and 3. and the amount under par. (a) 2. for the new plan year, the commissioner shall include any increase or decrease necessary to reflect the amount, if any, by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1) in the current plan year.

(3) (a) If, during a plan year, the commissioner determines that the moneys under s. 20.145 (7) (a), (af) and (g), the amounts set under sub. (2) (a) and any increases in insurer assessments and provider discounts under s. 619.144 are not sufficient to cover plan costs, the commissioner may by rule increase the premium rates set under sub. (2) (a) 1. for the remainder of the plan year, subject to subs. (1) (b) 1. and (2) (a) 1. and s. 619.146 (2) (b), increase the assessments set under sub. (2) (a) 2. for the remainder of the plan year, subject to sub. (1) (b) 2. a., and increase the discount rate set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (b) 2. b.

(b) If, after increasing premium rates, assessments and discount rates under par. (a), the commissioner determines that there will still be a deficit and that

premium rates have been increased to the maximum extent allowable under par. (a), the commissioner shall further increase, in equal proportions, assessments set under sub. (2) (a) 2. and discount rates set under sub. (2) (a) 3., without regard to sub. (1) (b) 2. Insurers and providers affected by this paragraph may recover the assessment increase and the discount rate increase in the normal course of their respective businesses without time limitation, subject to s. 619.14 (4m).

(4) Using the procedure under s. 227.24, the commissioner may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the commissioner is not required to make a finding of emergency.

(5) Notwithstanding sub. (2) (a) (intro.), the commissioner shall set premium rates, insurer assessments and provider discount rates for the period beginning on January 1, 1998, and ending on June 30, 1998, in the manner provided in subs. (1), (2) (a), (3) and (4). This subsection applies to policies in effect on January 1, 1998, as well as to policies issued or renewed on or after January 1, 1998.

SECTION 4859cm. 619.145 of the statutes is repealed.

SECTION 4859mm. 619.146 of the statutes is created to read:

619.146 Choice of coverage. (1) (a) Beginning on January 1, 1998, in addition to the coverage required under s. 619.14, the plan shall offer to all eligible persons a choice of coverage, as described in section 2744 (a) (1) (C) of P.L. 104–191. Any such choice of coverage shall be major medical expense coverage.

(b) An eligible person may elect once each year, at the time and according to procedures established by the board, among the coverages offered under this section and s. 619.14. If an eligible person elects new coverage, any preexisting condition

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

(2) (a) Except as specified by the board, the terms of coverage under s. 619.14, including deductible reductions under s. 619.14 (5) (a), do not apply to the coverage offered under this section. Premium reductions under s. 619.165 do not apply to the coverage offered under this section.

(b) The schedule of premiums for coverage under this section shall be promulgated by rule by the commissioner, as provided in s. 619.143. The rates for coverage under this section shall be set such that they differ from the rates for coverage under s. 619.14 by the same percentage as the percentage difference between the following:

1. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 619.14.

2. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as the coverage offered under this section.

SECTION 4862m. 619.15 (1) of the statutes is amended to read:

619.15 **(1)** The plan shall operate subject to the supervision and approval of a board <u>of governors</u> consisting of representatives of 2 participating insurers which are nonprofit corporations, <u>representatives of</u> 2 other participating insurers, <u>3 health</u>

care provider representatives, including one representative of the State Medical Society of Wisconsin, one representative of the Wisconsin Health and Hospital Association and one representative of an integrated multidisciplinary health system, and 3 public members, including one representative of small businesses in the state, appointed by the commissioner for staggered 3–year terms. In addition, the commissioner, or a designated representative from the office of the commissioner, and the chairperson of the standing committee of each house of the legislature with jurisdiction over insurance shall be ~~a member~~ members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital or an insurer. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the plan or the parent or spouse of such an individual. The commissioner or the commissioner's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative and the chairpersons of the standing committees, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

SECTION 4863m. 619.15 (2) of the statutes is amended to read:

619.15 **(2)** Annually, the board shall make a report to the ~~members of the plan and to the chief clerk of each house of the legislature, for distribution to the~~ appropriate standing committees under s. 13.172 (3)~~,~~ and to the members of the plan summarizing the activities of the plan in the preceding calendar year. The annual report shall define the cost burden imposed by the plan on all policyholders in this state.

SECTION 4863pm. 619.15 (2m) of the statutes is created to read:

619.15 **(2m)** Annually, beginning in 1999, the board shall submit a report on or before June 30 to the legislature under s. 13.172 (2) and to the governor on the operation of the plan, including any recommendations for changes to the plan.

SECTION 4867cm. 619.15 (3) (c) of the statutes is amended to read:

619.15 **(3)** (c) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established ~~by the board~~ as provided under s. 619.143. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice.

SECTION 4869cm. 619.15 (3) (e) of the statutes is amended to read:

619.15 **(3)** (e) Establish for payment of covered expenses, a payment rate that is 10% less than the charges approved by the administering carrier for reimbursement of covered expenses under s. 619.14 (3). ~~A provider of a covered service or article may not bill an eligible person who receives the service or article for any amount by which the charge is reduced under this paragraph.~~

SECTION 4869mm. 619.15 (3) (f) of the statutes is created to read:

619.15 **(3)** (f) In consultation with the office, establish a choice of coverage under s. 619.146.

SECTION 4872mm. 619.15 (4) (c) of the statutes is repealed.

SECTION 4873mm. 619.15 (4) (d) of the statutes is repealed.

SECTION 4873pm. 619.15 (4) (e) of the statutes is repealed.

SECTION 4887cm. 619.16 (3) (em) of the statutes is repealed.

SECTION 4890c. 619.165 (1) (a) of the statutes is amended to read:

619.165 **(1)** (a) ~~The~~ Except as provided in s. 619.146 (2) (a), the board shall reduce the premiums established by the commissioner under s. 619.11 in conformity with ss. ~~619.14 (5)~~ 619.143 and 619.17, for the eligible persons and in the manner set forth in pars. (b) to (d).

SECTION 4891cm. 619.165 (1) (d) of the statutes is renumbered 619.165 (1) (d) 1. and amended to read:

619.165 **(1)** (d) 1. ~~The~~ Subject to subd. 2., the board shall establish and implement the method for determining the household income of an eligible person under par. (b).

SECTION 4891mm. 619.165 (1) (d) 2. of the statutes is created to read:

619.165 **(1)** (d) 2. In determining household income under par. (b), the board may consider information submitted by an eligible person on a completed federal profit or loss from farming form, schedule F, if all of the following apply:

a. The person is a farmer, as defined in s. 102.04 (3).

b. The person was not eligible to claim the homestead credit under subch. VIII of ch. 71 in the preceding taxable year.

SECTION 4891rm. 619.165 (3) of the statutes is amended to read:

619.165 **(3)** The commissioner shall forward to the board moneys received under s. 20.145 (7) (a) and (g) ~~in an amount sufficient~~ to reimburse the plan for premium reductions under sub. (1) and deductible reductions under s. 619.14 (5) (a).

SECTION 4895c. 619.167 of the statutes is repealed.

SECTION 4897m. 619.17 (1) of the statutes is amended to read:

619.17 **(1)** Subject to ~~s. 619.14 (5) (a)~~ ss. 619.143 and 619.146 (2) (b), a rating plan calculated in accordance with generally accepted actuarial principles.

SECTION 4900m. 619.17 (4) (a) of the statutes is amended to read:

619.17 **(4)** (a) Cost containment provisions established by the commissioner by rule, including managed care requirements.

SECTION 4901cm. 619.175 of the statutes is amended to read:

619.175 Waiver or exemption from provisions prohibited. Except as provided in s. 619.13 (1) ~~(a)~~, the commissioner may not waive, or authorize the board to waive, any of the requirements of this subchapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this subchapter.".".

15. Page 445, line 23: after that line insert:

"1371w. Page 1825, line 22: delete the material beginning with that line and ending with page 1826, line 2.".

16. Page 473, line 12: after that line insert:

"1373c. Page 1826, line 23: delete the material beginning with that line and ending with page 1827, line 5.".

17. Page 521, line 2: after that line insert:

"1455c. Page 1978, line 1: delete lines 1 to 9.".

18. Page 521, line 19: delete that line and substitute:

"1459c. Page 1982, line 6: delete lines 6 to 17.".

19. Page 525, line 15: after that line insert:

"1470c. Page 1987, line 18: delete the material beginning with that line and ending with page 1989, line 25.".

20. Page 525, line 15: after that line insert:

"1470h. Page 1990, line 25: after that line insert:

"(5mpx) STUDY ON FAMILY COVERAGE UNDER THE MANDATORY HEALTH INSURANCE RISK-SHARING PLAN. The office of the commissioner of insurance shall study the feasibility of providing family coverage under the mandatory health insurance risk–sharing plan under subchapter II of chapter 619 of the statutes, as affected by this act, for an individual who is eligible for coverage under that plan and for the members of the individual's family. The office shall also determine whether providing such a plan of family coverage would satisfy the requirements under the federal Health Insurance Portability and Accountability Act of 1996 to provide a choice of coverage. On or before April 1, 1998, the office shall report its findings, conclusions and recommendations to the appropriate standing committees in the manner provided under section 13.172 (3) of the statutes and to the joint committee on finance.".".

21. Page 525, line 15: after that line insert:

"1470j. Page 1991, line 1: before that line insert:

"(5xt) COLLECTION OF ASSESSMENTS AND PENALTIES. For each person who, before the effective date of this subsection, became eligible for and obtained coverage under the health insurance risk–sharing plan under subchapter II of chapter 619 of the statutes, as affected by this act, as a result of receiving a notice under section 619.12 (1) (am), (b) or (c) of the statutes, the commissioner of insurance shall levy and collect the assessment specified in section 619.135 (1) (a) of the statutes and, if applicable, impose and collect the penalty specified in section 619.135 (1) (c) of the statutes. The commissioner shall credit all assessments and penalties collected under this subsection to the appropriation account under section 20.145 (7) (g) of the statutes, as affected by this act.".".

22. Page 566, line 5: delete lines 5 to 16 and substitute:

"1637c. Page 2067, line 12: delete the material beginning with that line and ending with page 2068, line 7, and substitute:

"(1gmx) MANDATORY HEALTH INSURANCE RISK-SHARING PLAN. The treatment of sections 20.145 (7) (af), (b) and (g), 619.10 (1m), (2c), (2j), (2t), (3c), (3d), (3g), (3j), (8j) and (9), 619.115, 619.12 (1) (intro.) and (2) (b) 2., (c), (d), (e) (by SECTION 4830km) and (f), 619.123, 619.13 (1) (a), (b), (c) and (d) and (2), 619.135 (2) and (3), 619.14 (2) (a), (3) (intro.), (4) (intro.), (4m) and (5) (title), (a), (d) and (e), 619.143, 619.145, 619.146, 619.15 (1), (2), (2m), (3) (c), (e) and (f) and (4) (c), (d) and (e), 619.16 (3) (em), 619.165 (1) (a) and (3), 619.167, 619.17 (1) and (4) (a) and 619.175 of the statutes, the renumbering and amendment of sections 619.14 (6) and 619.165 (1) (d) of the statutes, the creation of sections 619.14 (6) (b) and 619.165 (1) (d) 2. of the statutes and SECTIONS 9127 (5xt) and 9327 (3m) of this act take effect on January 1, 1998.".".

23. Page 566, line 22: delete that line and substitute "111.91 (2) (n), 120.13 (2) (g) (by SECTION 2860f), 185.981 (4t) (by SECTION 3133m), 185.983 (1) (intro.) (by SECTION 3134m), 609.77, 609.78, 609.79, 619.14 (4) (a) and 632.895".

(END)