WISCONSIN LEGISLATIVE COUNCIL
INFORMATION MEMORANDUM

Healthy Wisconsin Proposal

Healthy Wisconsin is a health care plan that was included in the version of 2007 Senate Bill 40 (the 2007-08 Biennial Budget Bill) that was passed by the Senate. The bill, as amended, was adopted by the Senate on Tuesday, June 26, 2007 by a vote of Ayes, 18; Noes, 15. The version of Senate Bill 40 passed by the Assembly on July 10, 2007, does not contain this proposal.

The Healthy Wisconsin health care plan provides health care coverage to state residents and employees. The coverage provided is coverage equivalent to the coverage under the state employee health care plan that is in effect on January 1, 2007. In addition, the plan provides coverage for mental health services and alcohol and drug abuse treatment on parity with coverage for physical conditions, and preventive dental care for children under the age of 18.

The plan is administered by the Healthy Wisconsin Authority, and funded by assessments on employers, employees, self-employed individuals, and individuals without earned income, who either meet specified residency requirement, are gainfully employed in this state, or both. The assessments are collected and deposited into the Healthy Wisconsin trust fund and released to the Healthy Wisconsin Board of Trustees for payment to health care networks and providers.

Individuals in the plan may receive health care services from a certified health care network, or through a fee-for-service option. To the extent that the individual chooses a low cost option available in the individual's area, the person pays no premium for the option. However, if a higher cost option is selected, the person pays an additional amount for that option.

HEALTHY WISCONSIN AUTHORITY

The Healthy Wisconsin health care ("Healthy Wisconsin") plan is governed by the Healthy Wisconsin Authority, a public body corporate and politic created in ch. 260, Stats. The authority is governed by a Board of Trustees comprised of the following members appointed by the Governor, with advice and consent of the Senate, for staggered six year terms:

- Four members selected from a list of names submitted by statewide labor or union coalitions. One of these members must be a public employee.
- Four members selected from a list of names submitted by statewide business and employer organizations. One of these members must be a public employer.

- One member selected from a list of names submitted by statewide public school teacher labor organizations.
- One member selected from a list of names submitted by statewide small business organizations.
- Two members who are farmers, selected from a list of names submitted by statewide general farm organizations.
- One member who is a self-employed person.
- Three members selected from a list of names submitted by statewide health care consumer organizations.

In addition, there are five nonvoting members: the Secretary of Employee Trust Funds, who serves as the chairperson of the board until a chairperson is elected by the membership; and four nonvoting members who are selected from the Healthy Wisconsin advisory committee, created in the legislation, who are health care personnel and administrators.

The Board of Trustees is required to do all of the following:

- Establish and administer a health care system in this state that ensures that all eligible persons have access to high quality, timely, and affordable health care. In doing so, the board must seek to attain goals of universal access by state residents to health care; maintaining and improving choice of providers and high quality health care; and implementing cost containment strategies that retain affordable coverage.
- Establish, fund, and manage the plan.
- Appoint an executive director, who serves at the pleasure of the board.
- Provide for mechanisms to enroll every eligible resident in the state under the plan.
- Create a program for consumer protection and a process to resolve disputes with providers.
- Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the board. Any person who is adversely affected by a board eligibility determination or any other determination is entitled to judicial review of the determination.
- Submit an annual report on its activities to the Governor and Chief Clerk of each house of the Legislature.
- Contract for annual, independent program evaluations and financial audits that measure the extent to which the plan is achieving the goals outlined for the plan. The board may not enter into a contract with the same auditor for more than six years.
- Accept bids from health care networks in accordance with the criteria set out in the plan, or make payments to fee-for-service providers in accordance with the plan.

The board must consult with the Department of Employee Trust Funds in determining the most effective and efficient way of purchasing health care benefits.

- Audit health care networks and providers to determine if their services meet the plan objectives and criteria.

The board is granted all the powers necessary or convenient to carry out the purposes and provisions of Healthy Wisconsin. In addition, the board may:

- Adopt, amend, and repeal bylaws, policies, and procedures for the regulation of its affairs and the conduct of its business.
- Have a seal and alter the seal at pleasure.
- Maintain an office.
- Sue and be sued.
- Accept gifts, grants, loans, or other contributions from private or public sources.
- Establish the authority's annual budget and monitor the fiscal management of the authority.
- Execute contracts and other instruments, including contracts for any professional services required for the authority.
- Employ any officers, agents, and employees that it may require and determine their qualifications and compensation.
- Procure liability insurance.
- Contract for studies on issues, as identified by the board or by the advisory committee, that relate to the plan.
- Borrow money, as necessary on a short-term basis, to address cash flow issues.
- Compel witnesses to attend meetings and to testify upon any necessary matter concerning the plan.

An advisory committee advises the board on multiple health-related issues. The advisory committee is comprised of various categories of health care professionals and health care administrators.

ELIGIBILITY

Generally

Generally, an individual is covered under Healthy Wisconsin if the individual is under age 65 and has maintained his or her place of permanent abode in this state for at least 12 months, and maintains a substantial presence in this state. The board is required to define "place of permanent abode" and "substantial presence in this state."

Individuals under 65 years of age are eligible for Healthy Wisconsin if they have maintained a place of permanent abode and maintain a substantial presence in Wisconsin.

Gainfully Employed

If a person and the members of the person's immediate family do not meet the residency requirement, but the person is **gainfully employed** in this state, as defined by the board, the person and the members of the person's immediate family are eligible to participate in the plan.

Children

If a **child under age 18** resides with his or her parent in this state but the parent does not yet meet the residency requirement, the child is eligible to participate in the plan regardless of the length of time the child has resided in this state.

Individuals who are gainfully employed in Wisconsin, children, and pregnant women are eligible for Healthy Wisconsin even if they do not meet the residency requirement.

Pregnant Women

A **pregnant woman** who resides in this state who does not yet meet the residency requirement is eligible to participate in the plan regardless of the length of time the pregnant woman has resided in this state.

Collective Bargaining Agreements

A person who is otherwise eligible to participate in Healthy Wisconsin and who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2009, is not eligible to participate in the plan until the day on which the collective bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified, or renewed.

Persons Not Eligible

An individual is **not eligible** for Healthy Wisconsin if one or more of the following applies:

- The individual is age 65 or older.
- The individual is eligible for health care coverage from the federal government or a foreign government.
- The individual is an inmate of a penal facility, as defined in s. 19.32 (1e).
- The individual is placed or confined in, or committed to, an institution for the mentally ill or developmentally disabled.
- The individual is eligible for Medical Assistance or BadgerCare, unless a waiver has been granted by the federal government to provide coverage under Healthy Wisconsin to these individuals.

FUNDING OF THE PLAN; ASSESSMENTS

The plan is funded by a variety of assessments on employers, employees, and self-employed persons. Individuals who have no income from wages are also charged an assessment. The assessment rates are set by the board and must be within the following ranges:

Employees

For an employee who is under the age of 65, a percent of wages that are subject to the Social Security tax (Social Security wages) that is **at least 2% and not more than 4%**, subject to the following:

1. If the employee has Social Security wages that are **150% of the poverty line or less**, the employee may not be assessed.

2. If the employee has no dependents and his or her social security wages are **more than 150% but less than 200% of the poverty line** the assessment shall be in an amount, as determined by the board on a sliding scale based on the employee's Social Security wages, that is between 0% and 4% of the employee's Social Security wages.

3. If the employee has one or more dependents, or is a single individual who is pregnant, and the employee's Social Security wages are **more than 150% but less than 300% of the poverty line** the assessment shall be in an amount, as determined by the board on a sliding scale based on the employee's Social Security wages, that is between 0% and 4% of the employee's Social Security wages.

The Healthy Wisconsin Board of Trustees must establish assessments to be paid by employers and other individuals and by employees.

Self-Employed Individuals

For a self-employed individual who is under the age of 65, a percent of Social Security wages that is **at least 9% and not more than 10%**.

Individuals with No Social Security Wages

For individuals with no Social Security wages, **10% of federal adjusted gross income,** up to the maximum amount of income that is subject to Social Security tax.

Employers

The board must calculate an assessment for an employer that is a percent of aggregate Social Security wages paid that is at least **9% and not more than 12%.**

Adjustment of Assessments

The board may increase or decrease the assessments annually. If the increase exceeds the annual percentage increase for medical inflation, the board must seek legislative approval for the increase.

The Department of Revenue must develop a method for collecting the assessments. The assessments are deposited into the Healthy Wisconsin Trust Fund. The funds are released to the board for payment for the health care coverage under the plan.

HEALTH CARE COVERED BY PLAN

The plan must provide the same benefits as those that were in effect as of January 1, 2007, under the state employee health plan. The board may adjust the plan benefits to provide additional cost-effective treatment options if there is evidence-based research that the options are likely to reduce health care costs, avoid health risks, or result in better health outcomes.

The plan must also provide coverage for mental health services and alcohol or other drug abuse treatment to the same extent as the plan covers treatment for physical conditions, and coverage for preventive dental care for children up to 18 years of age.

Healthy Wisconsin will provide the same coverage as provided under the state employee health plan, plus parity for mental health and alcohol and drug abuse treatment, and preventive dental care for children.

COST-SHARING

No Cost-Sharing

There is no copayment or coinsurance for the following services:

- Prenatal care for pregnant women.
- Well-baby care.
- Medically appropriate examinations and immunizations for children up to 18 years of age.
- Medically appropriate gynecological exams, Papanicolaou ("Pap") tests, and mammograms.
- Medically appropriate regular medical examinations for adults, as determined by best practices.
- Medically appropriate colonoscopies.
- Preventive dental care for children up to 18 years of age.
- Other preventive services or procedures, as determined by the board, for which there is scientific evidence that exemption from cost sharing is likely to reduce health care costs or avoid health risks.
- Chronic care services, provided that the participant receiving the services is participating in, and complying with, a chronic disease management program as defined by the board.

Coinsurance

A participant, regardless of age, who receives health care services from a **specialist provider without a referral from his or her primary care provider** under the plan is required to pay **25%** of the cost of the services provided.

Copayments

A **general copayment** for a participant who is 18 years of age or older on January 1 of that year is **$20** for medical, hospital, and related health care services, as determined by the board.

A participant who is 18 years of age or older must pay a co-payment of **$60** for **inappropriate emergency room use**, as determined by the board.

For prescription drugs, all participants, regardless of age, pay the following:

- **$5** for each prescription of a **generic drug that is on the formulary** determined by the board.
- **$15** for each prescription of a **brand-name drug that is on the formulary** determined by the board.
- **$40** for each prescription of a **brand-name drug that is not on the formulary** determined by the board.

Deductibles

During any year, a participant who is **18 years of age or older** on January 1 of that year must pay a deductible of **$300**, which applies to all covered services and articles.

During any year, a **family consisting of two or more participants who are 18 years of age or older** on January 1 of that year must pay a deductible of **$600**, which applies to all covered services and articles.

Single adults must pay a yearly deductible of $300. Families consisting of two or more adults must pay a yearly deductible of $600.

The board is permitted to reduce these deductible amounts.

During any year, a participant who is **under 18 years of age** on January 1 of that year pays **no deductible**.

Except for copayments and coinsurance, the plan shall provide a participant with full coverage for all covered services and articles after the participant has received covered services and articles totaling the applicable deductible amount, **regardless of whether the participant has paid the deductible amount.**

Providers must charge the payment rate established by the board for services or articles to which the deductible applies, if the participant is covered by the fee-for-service option, or the applicable network rate for the service or article, as determined by the board, if the person is in a network plan.

Generally, a provider of a covered service or article to which a deductible applies must accept this payment rate as payment in full for the covered service or article, and may not bill any additional amount to the person.

Except for prescription drugs, a provider may not refuse to provide a covered service or article to which a deductible applies on the basis that the participant does not or has not paid the applicable deductible amount before the service or article is provided.

Finally, a provider may not charge any interest, penalty, or late fee on any deductible owed by a participant unless the deductible owed is at least six months past due and the provider has provided the participant with notice of the interest, penalty, or late fee at least 90 days before it is due. Interest may not exceed 1% per month, and any penalty or late fee may not exceed the provider's reasonable cost of administering the unpaid bill.

Annual Maximums

The annual maximum for out-of-pocket cost-sharing is $2,000 for each participant who is 18 years of age or older as of January 1 of any given year; and $3,000 for a family consisting of two or more participants.

NETWORKS AND PROVIDERS

The board may establish areas in the state, which may be counties, multi-county regions, or other areas, for the purpose of receiving bids from health care networks.

Each area of the state must have a fee-for-service option and, if available, network option for receiving health care services.

There must be a **fee-for-service option** and **network options** offered in each area, to the extent that networks exist in an area.

Fee-for-Service Option

Under the fee-for-service option, participants must choose a primary care provider, may be referred by the primary care provider to any medical specialist, and may be admitted by the primary care provider or specialist to any hospital or other facility, for the purpose of receiving the benefits provided under Healthy Wisconsin. Under this option, the board, with the assistance of one or more administrators chosen by a competitive bidding process and under contract with the board, pays directly for all covered health care services and articles, at the provider payment rates established by the board.

Network Option

To the extent that networks exist in an area, the **networks must be certified** by the board in order to bid to provide health care services in an area. Bids from certified networks are ranked by the board on cost and quality measures.

A health care network qualifies to be certified if it does all of the following:

- Demonstrates to the satisfaction of the board that the fixed monthly risk-adjusted amount that it bids to provide participants with the specified health care benefits reasonably reflects its estimated actual costs for providing participants with these benefits in light of its underlying efficiency as a network, and has not been artificially underbid for the predatory purpose of gaining market share.
- Will spend at least 92% of the revenue it receives on one of the following:
    - Payments to health care providers in order to provide the health care benefits specified in the statutes to participants who choose the health care network.
    - Investments that the health care network has reasonably determined will improve the overall quality or lower the overall cost of patient care.
- Ensures all of the following:
    - That participants living in an area that a health care network serves will not be required to drive more than 30 minutes, or, in a metropolitan area served by mass transit, spend more than 60 minutes using mass transit facilities, in order to reach the offices of at least two primary care providers, as defined by the board.
    - That physicians, physician assistants, nurses, clinics, hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment, are conveniently available to participants living in every part of the area that the health care network serves.
- Ensures that participants have access, 24 hours a day, 7 days a week, to a toll-free hotline and help desk that is staffed by persons who live in the area and who have been fully trained to communicate the benefits and the choices of providers that participants have in using the health care network.
- Ensures that each participant who chooses the health care network selects a primary care provider who is responsible for overseeing all of the participant's care.
- Will provide each participant with medically appropriate and high-quality health care, including mental health services and alcohol or other drug abuse treatment, in a highly coordinated manner.
- Emphasizes, in its policies and operations, the promotion of healthy lifestyles; various forms of preventive care, including disease and chronic care management; best practices, including the appropriate use of primary care, medical specialists, medications, and hospital emergency rooms; and the utilization of continuous quality improvement standards and practices that are generally accepted in the medical field.

- Has developed and is implementing a program, including providing incentives to providers when appropriate, to promote health care quality, increase the transparency of health care cost and quality information, ensure the confidentiality of medical information, and advance the appropriate use of technology.

- Has entered into shared service agreements with out-of-network medical specialists, hospitals, and other facilities, including medical centers of excellence in the state, through which participants can obtain, at no additional expense to participants beyond the normally required cost-sharing, the services of out-of-network providers that the network's primary care physicians have determined are necessary to ensure medically appropriate and high-quality health care, to facilitate the best outcome, or, without reducing the quality of care, to lower costs.

- Has in place a comprehensive, shared, electronic patient records and treatment tracking system and an electronic provider payment system.

- Has adopted and implemented a strong policy to safeguard against conflicts of interest.

- Has been organized by physicians or other health care providers, a cooperative, or an entity whose mission includes improving the quality and lowering the cost of health care, including the avoidance of unnecessary operating and capital costs arising from inappropriate utilization or inefficient delivery of health care services, unwarranted duplication of services and infrastructure, or creation of excess capacity.

- Agrees to enroll and provide the benefits specified in this chapter to all participants who choose the network, regardless of the participant's age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status, except that a health care network may do one of the following:

    - Limit the number of new enrollees it accepts if the health care network certifies to the board that accepting more than a specified number of enrollees would make it impossible to provide all enrollees with the specified benefits at the level of quality that the network is committed to maintaining, provided that the health care network uses a random method for deciding which new enrollees it accepts.

    - Limit the participants that it serves to a specific affinity group that is in existence as of December 31, 2007, such as farmers or teachers, that the health care network has certified to the board, provided that the limitation does not involve discrimination based on any of the factors of age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status and has neither been created for the purpose, nor will have the effect, of screening out higher-risk enrollees.

PAYMENT OF NETWORKS AND PROVIDERS

Networks are classified by the board by cost and quality. For payments to health care networks, the board must pay monthly to the lowest-cost or low-cost health care network that performs well on quality measures, the full risk-adjusted per-member per-month amount that was bid by the network. The dollar amount must be actuarially adjusted for the network participant based on age, sex, and other appropriate risk factors determined by the board. For a higher-cost network, the board must pay monthly to the chosen health care network an amount equal to the bid submitted by the network that the board classified as the lowest-cost network and as having performed well on quality measures. The dollar amount must be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board.

For payments to fee-for-service providers, the board must establish provider payment rates that will be paid to providers of covered services and articles that are provided to participants who choose the fee-for-service option. The payment rates must be fair and adequate to ensure that this state is able to retain the highest quality of medical practitioners. The board must limit increases in the provider payment rate for each service or article such that any increase in per-person spending under the plan does not exceed the national rate of medical inflation.

No Additional Payments by Participants

An individual who selects a lowest-cost or low-cost option available in the area, whether a network option or the fee for service option, pays nothing extra for coverage under that option. Also, if the fee-for-service option is the only option available in an area, there is no additional payment required.

Additional Payments by Participants

Networks

An individual who lives in an area where there is more than one network option and who selects a network that is classified as a higher-cost network pays the difference between the lowest-cost and higher-cost network.

Fee-for-Service

An individual who selects a fee-for-service option, that is classified higher-cost option, in an area where a one or more low-cost or lowest-cost networks exist, pays the following additional payment:

- **In an area with three or more certified lowest or low-cost health care networks**: the participant must pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established for the fee-for-service option. The amount paid may not exceed $100 per month for an individual, or $200 per month for a family, as adjusted for medical inflation.
- **In an area with two certified lowest or low-cost health care networks**: The participant must pay the difference between the cost of the lowest-cost health

care network and the monthly risk-adjusted cost established for the fee-for-service option. The amount paid may not exceed $65 per month for an individual, or $125 per month for a family, as adjusted for medical inflation.

- **In an area with one certified lowest or low-cost health care network**: the participant must pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established for the fee-for-service option, except that the amount paid may not exceed $25 per month for an individual, and $50 per month for a family, as adjusted for medical inflation.

TREATMENT OF OTHER HEALTH CARE COVERAGE

Generally, employers may provide coverage in addition to that provided under Healthy Wisconsin, as a benefit to their employees.

For school district professional employees, for the purposes of determining if a school district has maintained fringe benefits for the purposes of a qualified economic offer, a municipal employer shall be considered to have maintained its health care coverage benefit if the employer provides health care coverage to its school district professional employees through Healthy Wisconsin and supplements that coverage, if necessary, to produce a health care coverage benefit that is actuarially equivalent to the health care coverage benefit in place before the school district professional employees become covered under the Healthy Wisconsin. If a dispute arises concerning the municipal employer's determination of actuarial equivalence or what supplemental benefits are sufficient to achieve actuarial equivalence, the dispute is resolved by a neutral person who is designated by the Wisconsin Employment Relations Commission.

Persons currently participating in the Health Insurance Risk Sharing Plan (HIRSP) would no longer be eligible for HIRSP if they are covered under Healthy Wisconsin.

Persons receiving health care services from special state programs such as aid for treatment of kidney disease, cystic fibrosis, and hemophilia, and reimbursement for AZT and pentadimine, would receive treatment for those conditions from Healthy Wisconsin.

Persons under Medicaid and BadgerCare would continue to receive health care under those programs, unless a waiver is granted by the federal government.

OFFICE OF OUTREACH, ENROLLMENT, AND ADVOCACY

The Healthy Wisconsin Board of Trustees is required to establish an office of outreach, enrollment, and advocacy. The office must do the following:

- Engage in aggressive outreach to enroll eligible persons and participants in their choice of health care coverage under the plan.

- Assist eligible persons in choosing health care coverage by examining cost, quality, and geographic coverage information regarding their choice of available networks or providers.

- Inform plan participants of the role they can play in holding down health care costs by taking advantage of preventive care, enrolling in chronic disease management programs if appropriate, responsibly utilizing medical services, and engaging in healthy lifestyles. The office shall inform participants of networks or workplaces where healthy lifestyle incentives are in place.

- At the direction of the board, establish a process for resolving disputes with providers.

- Act as an advocate for plan participants having questions, difficulties, or complaints about their health care services or coverage, including investigating and attempting to resolve the complaint.

- If a participant's complaint cannot be successfully resolved, inform the participant of any legal or other means of recourse for his or her complaint. If the complaint involves a dispute over eligibility or other determinations made by the board, the participant shall be directed to the appeals process for board decisions.

- Provide information to the public, agencies, legislators, and others regarding problems and concerns of plan participants and, in consultation with the health care advisory committee make recommendations for resolving those problems and concerns.

- Ensure that plan participants have timely access to the services provided by the office.

Office employees must adhere to conflict of interest requirements.

PROPERTY TAX RELIEF PROVISION

For property tax levies imposed for 2009, if any taxing jurisdiction, reduces the costs of providing health care coverage to its employees as a result of providing that coverage under Healthy Wisconsin together with any supplemental coverage needed to ensure that the health care coverage provided to employees of the taxing jurisdiction is actuarially equivalent to the coverage they received in 2008, the taxing jurisdiction must distribute at least 50% of the savings to the property taxpayers in the taxing jurisdiction as a reduction in the January 1, 2009 property tax assessments.

The reduction is calculated based on the equalized value of the property, and must reduce the property taxes otherwise payable in that year.

LEGISLATIVE FINDINGS

The part of the Senate amendment relating to Healthy Wisconsin contains extensive legislative findings relating to the health care system in Wisconsin and nationally.

This memorandum is not a policy statement of the Joint Legislative Council or its staff. The memorandum was prepared by Laura Rose, Deputy Director, on July 13, 2007.

WISCONSIN LEGISLATIVE COUNCIL
One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
Telephone: (608) 266-1304 • Fax: (608) 266-3830
Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc