This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See Wisconsin state page.

Wisconsin operates one of the largest private APCDs in the country, even though it is not mandated by statute. The Wisconsin Health Information Organization (WHIO), a private organization, gathers and makes healthcare claims data publicly accessible. With insurance claims data from sixteen commercial health plans and the state Medicaid program, the database provides consumers information about
cost, population health, prescribing patterns, and more.

Wisconsin confers merger review authority of healthcare consolidation to the attorney general for all nonprofit hospitals. Not only does it mandate notice to the AG, it requires approval from both the AG and relevant state agencies.

In healthcare market regulation, Wisconsin received a $2.4 million grant from CMS in 2014 to develop a state innovation plan to reduce Medicare and Medicaid costs. Wisconsin was one of the first five states to receive an approved 1332 waiver from the federal government. Recent state law mandates the Wisconsin Health Care Stability Plan (WIHSP), a publicly-funded reinsurance program, to expand access to care, reduce premium increases, keep more individuals insured, and entice insurers to offer insurance plans in the state. The program will pay insurers up to eighty percent of claims greater than $50,000 but less than $250,000. Wisconsin's 1332 State Innovation Waiver to implement WIHSP was approved by HHS through 2023.

See below for an overview of existing Wisconsin state mandates. Click on citation tab for detailed information of...
Recent Action in Healthcare System Reform

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services. This bill defines "originating site" as the location where a patient is located for telehealth services and that originates telehealth service to another qualified site, such as the office of a healthcare services provider, a hospital, a rural health clinic, or any other location deemed acceptable by the health insurance entity.

Expands existing coverage parity/reimbursement parity requirements. Requires a health insurance entity to reimburse a facility hosting a patient for a telehealth encounter an originating site fee in accordance with applicable rules and amounts established by the Centers for Medicare and Medicaid Services (CMS).

Adds a private location the patient deems appropriate to receive their healthcare services that is equipped to engage in telecommunication as a location a patient may receive provider-based telemedicine services and requires an in-person encounter between the healthcare service provider, the provider's practice group, or the healthcare system and the patient within 24 months prior to a telehealth encounter prior to the provider-based telemedicine service.

Requires a health insurance entity to consider any remote patient monitoring (RPM) service a covered service if the
same service is covered by Medicare. As introduced, makes various changes to the law concerning the electronic delivery of health care and its coverage under insurance policies. This bill adds that telehealth is subject to utilization review in the same manner as an in-person encounter under the Health Care Service Utilization Review Act. This bill requires a health insurance entity to reimburse a facility hosting a patient as part of a telehealth encounter an originating site fee in accordance with applicable rules and amounts established by the Centers for Medicare and Medicaid Services. This bill defines “originating site” as the location where a patient is located for telehealth services and that originates telehealth service to another qualified site, such as the office of a healthcare services provider, a hospital, a rural health clinic, or any other location deemed acceptable by the health insurance entity.

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Insurance Amendments. This bill amends and enacts provisions under the Insurance Code and related to certain health benefit plans and the Health Reform Task Force.

An act relating to health care reform implementation. This bill proposes to create additional reporting, certification, and budget requirements for accountable care organizations; direct hospitals to report certain rate increases to the Green Mountain Care Board; and impose new requirements on contracting between health plans and health care providers. It would require the Green Mountain Care Board to review annually the budgets of designated and specialized service
agencies and preferred provider organizations. The bill would specify that the Green Mountain Care Board’s membership must include a health care professional, require the Board to begin exercising its rate-setting authority and to establish site-neutral reimbursement amounts, and direct the Board to review and approve contracts between health plans and health care providers. The bill would also impose limits on health insurance rate increases attributable to administrative expenses and require the Agency of Human Services to report on two-year accountable care organization budget and reporting cycles and on the likely effects of attributing or not attributing State employees and public school employees to an accountable care organization.

An act relating to miscellaneous health care provisions. This bill proposes to address several health care-related topics, including mental health, hospital budget review, expansion of VPharm coverage for certain beneficiaries, and the review and modification of prior authorization requirements.

Health benefit plans; special exception. Eliminates provisions of the Code of Virginia authorizing health carriers to sell, issue, or offer for sale any health benefit plan that would otherwise not be
permitted to be sold, issued, or offered for sale due to conflict with the requirements of the federal Patient Protection and Affordable Care Act (PPACA), to the extent that the requirements of the PPACA are amended by any federal law.

Health insurance; essential health benefits; preventive services. Requires a health carrier offering or providing a health benefit plan, including (i) catastrophic health insurance policies and policies that pay on a cost-incurred basis; (ii) association health plans; and (iii) plans provided by a multiple-employer welfare arrangement, to provide, as an essential health benefit, coverage that includes preventive care. The bill defines essential health benefits as those general categories and those items and services within such categories that are covered in accordance with regulations issued pursuant to the Patient Protection and Affordable Care Act in effect as of January 1, 2019.

Recent Litigation

• Recent Litigation
Court's decision in NFIB v. Sebellius and the Tax Cuts and Jobs Act of 2017. In NFIB v. Sebelius, the National Federation of Independent Business and 26 state attorneys general challenged Congress' ability to require Americans to purchase health insurance, as doing so would regulate inaction, as opposed to action, in commerce. Finding justifications grounded in interstate commerce or the Necessary and Proper clause lacking, Chief Justice Roberts rested the constitutionality of the individual mandate on the fact that it functioned as a tax – citizens had to prove that they had qualifying health insurance or pay the shared responsibility payment, which was collected by the I.R.S. when people filed their tax returns. Robert's opinion did not save the individual mandate from controversy for long, however. Following the 2016 election of Donald Trump, the Republican attack on Obamacare continued with new fervor. After numerous failed attempts to repeal the law directly, Congress modified the ACA as part of its tax reform package, the Tax Cuts and Jobs Act of 2017, in December 2017. The tax bill changed the penalty for failing to have health insurance from $695 for an adult to $0, eliminating the tax. Republicans did so for three reasons. First, the
Congressional Budget Office predicted that eliminating the penalty would reduce the federal deficits by $338 million between 2018 and 2027, which Republicans needed to successfully pass their planned tax cuts. Second, it allowed them to claim that they had delivered on their campaign promises of repealing at least some portion of the ACA. Third, it would allow them to once again challenge the constitutionality of the individual mandate, as it no longer functioned as a tax, and as a result, challenge the entirety of the ACA.

In February 2018, 20 state attorneys general filed suit in the Northern District of Texas against the Department of Health and Human Services and the Internal Revenue Service (Texas v. U.S.) claiming that under the Supreme Court's ruling in NFIB, the elimination of the tax penalty voids the constitutionality of the individual mandate and the entirety of the Patient Protection and Affordable Care Act ("ACA"). They argue that because the Supreme Court's validation of the ACA's constitutionality in 2012 "rested solely on the flimsy support of Congress' authority to tax," now that the tax penalty is eliminated, the entire law is unconstitutional and invalid. On April 9, 2018, another group of state attorneys general filed a motion to intervene in the
case to protect the benefits promised to their citizens and more than $650 billion in federal money scheduled to come to the states under the ACA to provide health care. U.S. District Judge Reed O'Connor heard oral arguments in a three-hour hearing on September 5, 2018. On December 14, 2018, he issued an opinion that struck down the entire ACA as unconstitutional. The judge ruled in favor of the plaintiffs by determining that the "individual mandate" is no longer a tax and is therefore an unconstitutional exercise of congressional authority. The judge also found that the individual mandate was inseverable from the rest of the ACA, which makes the entire ACA unconstitutional. The intervening states appealed the case to the 5th Circuit Court of Appeals and the U.S. House of Representatives joined the appeal. On December 18, 2020, the three-judge panel of the 5th Circuit ruled two to one that the individual mandate was unconstitutional in the absence of a tax penalty, and remanded the case back to Judge O'Connor in the Texas District Court to determine whether the individual mandate can be severed from the rest of the ACA or the entire law must fall with the individual mandate.
Twenty democratic states and the House of Representatives immediately appealed the 5th Circuit decision to remand the case on severability (California et al. v. Texas et al.) to the Supreme Court for an expedited review in the 2019-2020 term, but the court declined the motion on January 21, 2020. The States and the House of Representatives also asked the 5th Circuit to review the decision en banc, meaning in front of the entire 5th Circuit, and the fourteen judge court decided along party lines (8-6) to decline the request to review the decision on January 29, 2020.

However, in March 2020, the Supreme Court granted review of the 5th Circuit’s decision for the 2020-2021 term and consolidated the two cases Texas v. United States and California v. Texas. The Supreme Court review would considerably fast-track the case by bypassing the lower court remand. The case is expected to be heard in Fall 2020 (oral arguments) and decided by June 2021.

[CBO predicted that the savings would result from the nearly 13 million people]
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