State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-2885/3
PJK/RAC/MES/JK:jld:nwn

2007 SENATE BILL 562

March 5, 2008 - Introduced by Senator ERPENBACH. Referred to Committee on Health, Human Services, Insurance, and Job Creation.

AN ACT ***to repeal*** 40.05 (4) (ar), 609.01 (7), 609.10, 609.20 (1m) (c), 609.20 (1m) (d), 628.36 (4) (b) 1., 628.36 (4) (b) 2. and 628.36 (4) (b) 3.; ***to renumber and amend*** 40.51 (6) and 62.61; ***to amend*** 13.172 (1), 13.48 (13) (a), 13.62 (2), 13.95 (intro.), 16.002 (2), 16.004 (4), 16.004 (5), 16.004 (12) (a), 16.045 (1) (a), 16.41 (4), 16.417 (1) (a), 16.52 (7), 16.528 (1) (a), 16.53 (2), 16.54 (9) (a) 1., 16.70 (2), 16.765 (1), 16.765 (2), 16.765 (4), 16.765 (5), 16.765 (6), 16.765 (7) (intro.), 16.765 (7) (d), 16.765 (8), 16.85 (2), 16.865 (8), 40.05 (4) (ag) (intro.), 40.05 (4) (b), 40.05 (4) (be), 40.51 (1), 40.51 (2), 40.51 (7), 40.51 (8), 40.51 (8m), 40.52 (1) (intro.), 40.52 (2), 40.98 (2) (a) 1., 49.473 (2) (c), 49.68 (3) (d) 1., 49.683 (3), 49.685 (6) (b), 59.52 (11) (c), 60.23 (25), 66.0137 (4), 66.0137 (4m) (b), 66.0137 (5), 71.26 (1) (be), 77.54 (9a) (a), 100.45 (1) (dm), 111.70 (1) (dm), 111.70 (4) (cm) 8s., 120.13 (2) (b), 120.13 (2) (g), 230.03 (3), 285.59 (1) (b), 628.36 (4) (a) (intro.), 632.87 (5), 632.895 (10) (a), 632.895 (11) (a) (intro.), 632.895 (11) (c) 1., 632.895 (11) (d), 632.895 (12) (b) (intro.), 632.895 (12) (c), 632.895 (13) (a), 632.895 (13) (b),

632.895 (14) (b) and 632.895 (14) (c); and ***to create*** 13.94 (1) (dj), 13.94 (1s) (c) 5., 16.004 (7d), 16.004 (7h), 20.855 (4m), 25.17 (1) (gd), 25.775, 40.05 (4) (a) 4., 40.05 (4g) (d), 40.51 (6) (b), 40.52 (1m), 49.45 (54), 49.687 (1m) (d), 62.61 (1) (b), 70.11 (41p), 109.075 (9), 111.91 (2) (pt), 149.12 (2) (em), chapter 260, 632.895 (8) (f) 4., 632.895 (9) (d) 4., 632.895 (10) (b) 6., 632.895 (11) (e) 3. and 632.895 (14) (d) 7. of the statutes; **relating to:** the establishment of the Healthy Wisconsin Plan and the Healthy Wisconsin Authority, granting rule–making authority, and making an appropriation.

Analysis by the Legislative Reference Bureau

Healthy Wisconsin Authority and Plan

This bill creates the Healthy Wisconsin Authority (HWA), a public body corporate and politic that is created by state law but that is not a state agency. HWA is governed by a board of trustees (board) consisting of, as nonvoting members, the secretary of employee trust funds and four members of a health care advisory committee created in the bill, and all of the following voting members, nominated by the governor and with the advice and consent of the senate appointed, for staggered six–year terms: four members selected from a list of names submitted by statewide labor or union coalitions; four members selected from a list of names submitted by statewide business and employer organizations; 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; and three members selected from a list of names submitted by statewide health care consumer organizations.

Because HWA is not a state agency, numerous laws that apply to state agencies do not apply to HWA. However, HWA is treated like a state agency in the following respects, among others: 1) it is generally subject to the open records and open meetings laws; 2) it is treated like a state agency for purposes of the law regulating lobbying; 3) it is exempt from income tax, sales and use tax, and property taxes; 4) the Code of Ethics for Public Officials and Employees covers HWA; and 5) it is subject to auditing by the Legislative Audit Bureau.

HWA is unlike a state agency in many other ways, including: 1) it may approve its own budget without going through the state budgetary process; 2) its employees are not state employees, are not included in the state system of personnel management, and are hired outside the state hiring system; and 3) it is not subject

to statutory rule–making procedures, including requirements for legislative review of proposed rules. Unlike most other authorities, HWA may not issue bonds.

HWA must establish and administer a health care plan (plan), known as Healthy Wisconsin, for all eligible persons in the state. HWA must establish an office of outreach, enrollment, and advocacy to perform outreach services to enroll persons in the plan, to assist persons in choosing their health care coverage options, to act as an advocate for plan participants, and to provide information to the public, agencies, and legislators regarding the plan. HWA also must establish a health care advisory committee to advise HWA on various health matters, such as promoting healthier lifestyles, disease management, increasing transparency in health care cost and quality information, reducing health care costs, and confidentiality of medical information. The committee is comprised of the following members: at least one member each designated by the Wisconsin Medical Society, Inc., the Wisconsin Academy of Family Physicians, and the Wisconsin Hospital Association, Inc.; one member each designated by the president of the Board of Regents of the University of Wisconsin System, the president of the Medical College of Wisconsin, the Wisconsin Dental Association, and statewide organizations interested in mental health issues; two members designated by the Wisconsin Nurses Association, the Wisconsin Federation of Nurses and Health Professionals, and the Service Employees International Union; one member representing health care administrators; and one member representing health care professionals.

Plan eligibility

A person is eligible to participate in the plan if he or she has maintained his or her place of permanent abode in this state for at least 12 months, maintains a substantial presence in this state, is under 65 years of age, is not eligible for health care coverage from the federal or a foreign government, is not an inmate of a penal facility or confined in or committed to an institution for the mentally ill or developmentally disabled, and, unless a federal waiver is granted and in effect, is not eligible for a Medical Assistance (MA) program, including the BadgerCare Plus program, unless the MA program or an eligibility category under an MA program is not receiving federal matching funds for the benefits under the program or category. Under the bill, the Department of Health and Family Services (DHFS) is required to request a federal waiver allowing those eligible for MA to participate in the plan. Persons who are gainfully employed in the state and pregnant women who reside in this state are also eligible for the plan if they meet all of the eligibility criteria except that they have not maintained a permanent abode in this state for at least 12 months. Children under the age of 18 years who reside in this state with parents who have not maintained a permanent abode in this state for at least 12 months are also eligible regardless of how long they have lived in the state if they meet the other eligibility criteria.

Benefits and cost sharing

The plan must provide the same benefits that were in effect as of January 1, 2008, under the state employee health benefit plan. The board may adjust the benefits to provide additional cost–effective treatment options that would reduce health care costs, avoid health risks, or result in better health outcomes. In addition,

the plan must cover preventive dental care for children up to 18 years of age and must cover mental health services and alcohol and other drug abuse treatment to the same extent as the plan covers treatment for physical conditions. Generally, except for prescription drugs to which a deductible applies, and except for copayments for drugs, the board assumes the risk for and pays directly for prescription drugs provided to participants. The board is directed to replicate the prescription drug buying system developed by the Group Insurance Board for prescription drug coverage for state employees, and may join with other states to form a multistate purchasing group to negotiate with prescription drug manufacturers for reduced prices.

Certain specified preventive services, such as prenatal care, preventive dental care for children, and medically appropriate colonoscopies and gynecological exams, are covered without any cost sharing. Except for those specified preventive services, copayments during a year are $20 for medical and hospital and related services for persons who are at least 18 years of age on January 1 of that year. Certain other services, such as inappropriate emergency room use, have higher copayments. All persons, regardless of age, must pay copayments of $5 for generic prescription drugs, $15 for brand–name prescription drugs on the formulary determined by the board, and $40 for brand–name prescription drugs not on the formulary.

There is no deductible during a year for persons who are under age 18 on January 1 of that year. Persons who are at least 18 years of age on January 1 of a year must pay a deductible of $300 during that year, but the deductible amount is limited to $600 per year for families with two or more persons who are at least 18 years of age on January 1 of that year. The maximum out–of–pocket amount for copayments, coinsurance, and deductibles is $2,000 a year for a person who is at least 18 years of age on January 1 of that year, but not more than $3,000 a year for a family consisting of two or more persons.

The bill contains certain requirements for providers with respect to charging interest on deductible amounts not paid, providing services to persons who have not paid a deductible amount, and charging for services to which a deductible applies.

Choice of health care network or fee–for–service option

Under the bill, the board may establish areas in the state for the purpose of receiving bids from health care networks. In each area designated by the board, the plan must offer participants two options for the delivery of their health care services: a fee–for–service option and a health care network (network) option. Annually, the board must solicit bids from networks, which are defined in the bill as a provider–driven, coordinated group of health care providers and facilities. Only qualifying networks may be selected to provide services in an area. The bill specifies various criteria related to a network's organization and provision of services that a network must satisfy to be qualifying. On the basis of the bids and other information submitted by the networks, the board must certify which networks are qualifying, and then classify the certified networks according to price and quality measures as the lowest–cost network, low–cost networks, and higher–cost networks.

During annual open enrollment periods, plan participants may select a fee–for–service option or a certified network for the delivery of their health care.

Participants who do not make a selection are assigned randomly to the lowest–cost network or a low–cost network, or to a fee–for–service option that is the lowest–cost option. In addition, a participant who selects a higher–cost network or a fee–for–service option and who fails to pay any required additional premium amount will be assigned randomly to the lowest–cost network or a low–cost network, or to a fee–for–service option that is the lowest–cost option. Each participant must select a primary care provider who is responsible for overseeing all of the participant's care.

On behalf of a participant who selects a network classified as the lowest–cost network or a low–cost network, the board pays to the network on a monthly basis the amount that the network bid, and the participant pays no additional amount as premium. On behalf of a participant who chooses a network classified as a higher–cost network, the board pays to the network on a monthly basis the amount that was bid by the lowest–cost network, and the participant must pay the difference between what the network bid and the amount that the board pays.

The board establishes provider payment rates for services provided under a fee–for–service option. A provider that provides services to a participant who has selected a fee–for–service option must accept the rate established by the board as the full payment and may not charge the participant any amount by which the provider's charge has been reduced. In addition to establishing provider payment rates, the board, with the assistance of actuarial consultants, establishes the monthly risk–adjusted cost of the fee–for–service option and classifies the fee–for–service option in the same manner as networks are classified. A participant who selects a fee–for–service option that is classified as a higher–cost choice must pay an additional amount, which is capped in the bill, that is based on the classification of the fee–for–service option chosen by the participant and the number of certified low–cost networks available to the participant. There is no additional cost to a participant who chooses a fee–for–service option if the board determines that there are no low–cost networks available to the participant.

Assessments on individuals and employers

Under the bill, the Department of Revenue (DOR) must impose and collect assessments that are calculated by the board, based on the board's anticipated revenue needs. The assessments may be collected from individuals and employers through the income tax system, or through another system devised by DOR.

Generally, the assessment for an individual who is the employee of another person is between 2 percent and 4 percent of the individual's social security wages. If the individual's social security wages are 150 percent or less of the federal poverty line, however, the assessment is zero. If such wages are between 150 percent and 300 percent of the poverty line, the assessment is on a sliding scale between zero and 4 percent, depending on the amount of the individual's social security wages and on the number his or her dependents.

The assessment on a self–employed individual is between 9 percent and 10 percent. The assessment on someone who is eligible to participate in the plan but who is neither self–employed nor the employee of another person is 10 percent of the individual's federal adjusted gross income, up to the maximum amount of the income subject to social security tax.

The maximum amount of an assessment that DOR may impose on a household, defined as an individual, his or her spouse, and his or her immediate family, as that term is defined by the board, is 4 percent of the annual limit on the contribution and benefit base of the Old–Age, Survivors, and Disability Insurance program, as calculated annually by the U.S. Social Security Administration. For 2008, this base is $102,000.

For an employer, the assessment calculated by the board must be between 9 percent and 12 percent of an employer's aggregate social security wages, except that for taxable year 2010 the assessment imposed on a small employer (an employer who has no more than ten employees) is 33 percent of the amount calculated that would otherwise be collected. For taxable year 2011, the assessment on a small employer is 67 percent of the amount calculated that would otherwise be collected.

The assessments that are collected by DOR must be deposited into the Healthy Wisconsin trust fund. The board may annually increase or decrease the assessment percentages for individuals and employers, but an annual increase may not exceed the percentage increase in medical inflation, unless otherwise provided by law.

Miscellaneous matters

Under current law, DHFS provides financial assistance to eligible persons who have chronic kidney disease, cystic fibrosis, or hemophilia for the cost of medical treatment for those diseases. This assistance is collectively referred to as the Chronic Disease Aids Program. Generally, a person with one of these chronic diseases who has other health care coverage is not eligible for assistance under the Chronic Disease Aids Program. Under the bill, a person with coverage under the plan is still eligible for assistance under the Chronic Disease Aids Program.

Under current law, the state is required to, and counties, cities, villages, and towns (political subdivisions) may, provide health care coverage through insurance or on a self–insured basis for their employees. The bill provides that the state and political subdivisions may provide for their employees health care benefits that are not provided under the plan, since state and political subdivision employees, if they satisfy the eligibility criteria, will have coverage under the plan.

Under the bill, if a entity that levies a property tax reduces the costs of providing health care benefits to its employees as a result of providing benefits under the plan, the entity must distribute at least 50 percent of the reduction amount as reduction in property taxes levied for 2010. The reduction amount for each taxpayer is based on the equalized value of the taxpayer's property.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 13.172 (1) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

13.172 **(1)** In this section, "agency" means an office, department, agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, and any authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 233, 234, 260, or 279.

SECTION 2. 13.48 (13) (a) of the statutes is amended to read:

13.48 **(13)** (a) Except as provided in par. (b) or (c), every building, structure or facility that is constructed for the benefit of or use of the state, any state agency, board, commission or department, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Healthy Wisconsin Authority, or any local professional baseball park district created under subch. III of ch. 229 if the construction is undertaken by the department of administration on behalf of the district, shall be in compliance with all applicable state laws, rules, codes and regulations but the construction is not subject to the ordinances or regulations of the municipality in which the construction takes place except zoning, including without limitation because of enumeration ordinances or regulations relating to materials used, permits, supervision of construction or installation, payment of permit fees, or other restrictions.

SECTION 3. 13.62 (2) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

13.62 **(2)** "Agency" means any board, commission, department, office, society, institution of higher education, council, or committee in the state government, or any

authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 232, 233, 234, 237, 260, or 279, except that the term does not include a council or committee of the legislature.

SECTION 4. 13.94 (1) (dj) of the statutes is created to read:

13.94 **(1)** (dj) Annually, conduct a financial audit of the Healthy Wisconsin Plan under ch. 260 and file copies of each audit report under this paragraph with the distributees specified in par. (b).

SECTION 5. 13.94 (1s) (c) 5. of the statutes is created to read:

13.94 **(1s)** (c) 5. The Healthy Wisconsin Authority for the cost of the audit under sub. (1) (dj).

SECTION 6. 13.95 (intro.) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

13.95 Legislative fiscal bureau. (intro.) There is created a bureau to be known as the "Legislative Fiscal Bureau" headed by a director. The fiscal bureau shall be strictly nonpartisan and shall at all times observe the confidential nature of the research requests received by it; however, with the prior approval of the requester in each instance, the bureau may duplicate the results of its research for distribution. Subject to s. 230.35 (4) (a) and (f), the director or the director's designated employees shall at all times, with or without notice, have access to all state agencies, the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Fox River Navigational System Authority, and to any books, records, or other documents maintained by such agencies or authorities and relating to their expenditures, revenues, operations, and structure.

SECTION 7. 16.002 (2) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.002 **(2)** "Departments" means constitutional offices, departments, and independent agencies and includes all societies, associations, and other agencies of state government for which appropriations are made by law, but not including authorities created in subch. II of ch. 114 or subch. III of ch. 149 and in chs. 231, 232, 233, 234, 235, 237, 260, and 279.

SECTION 8. 16.004 (4) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.004 **(4)** FREEDOM OF ACCESS. The secretary and such employees of the department as the secretary designates may enter into the offices of state agencies and authorities created under subch. II of ch. 114 or subch. III of ch. 149 and under chs. 231, 233, 234, 237, 260, and 279, and may examine their books and accounts and any other matter that in the secretary's judgment should be examined and may interrogate the agency's employees publicly or privately relative thereto.

SECTION 9. 16.004 (5) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.004 **(5)** AGENCIES AND EMPLOYEES TO COOPERATE. All state agencies and authorities created under subch. II of ch. 114 or subch. III of ch. 149 and under chs. 231, 233, 234, 237, 260, and 279, and their officers and employees, shall cooperate with the secretary and shall comply with every request of the secretary relating to his or her functions.

SECTION 10. 16.004 (7d) of the statutes is created to read:

16.004 **(7d)** CONTAINMENT OF HEALTH CARE COSTS. In consultation with the board of the Healthy Wisconsin Authority, the secretary shall establish, by rule, a program

to contain health care costs in this state during any year in which the board determines that health care costs increase at a rate exceeding the national average of medical inflation, as defined in s. 260.01 (4).

SECTION 11. 16.004 (7h) of the statutes is created to read:

16.004 **(7h)** EMPLOYER ASSESSMENTS TO THE HEALTHY WISCONSIN TRUST FUND. The secretary shall establish a methodology for allocating employer assessments among state agencies to pay the Healthy Wisconsin trust fund for the operation and funding of the Healthy Wisconsin Plan under ch. 260. State agencies shall pay, from appropriations used to fund fringe benefit costs of state employees, to the Healthy Wisconsin trust fund amounts determined by the secretary.

SECTION 12. 16.004 (12) (a) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.004 **(12)** (a) In this subsection, "state agency" means an association, authority, board, department, commission, independent agency, institution, office, society, or other body in state government created or authorized to be created by the constitution or any law, including the legislature, the office of the governor, and the courts, but excluding the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Fox River Navigational System Authority.

SECTION 13. 16.045 (1) (a) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.045 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that

is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 232, 233, 234, 235, 237, 260, or 279.

SECTION 14. 16.41 (4) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.41 **(4)** In this section, "authority" means a body created under subch. II of ch. 114 or subch. III of ch. 149 or under ch. 231, 233, 234, 237, 260, or 279.

SECTION 15. 16.417 (1) (a) of the statutes is amended to read:

16.417 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority or the body created under subch. III of ch. 149 or under ch. 260.

SECTION 16. 16.52 (7) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.52 **(7)** PETTY CASH ACCOUNT. With the approval of the secretary, each agency that is authorized to maintain a contingent fund under s. 20.920 may establish a petty cash account from its contingent fund. The procedure for operation and maintenance of petty cash accounts and the character of expenditures therefrom shall be prescribed by the secretary. In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law,

including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 233, 234, 237, 260, or 279.

SECTION 17. 16.528 (1) (a) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.528 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 233, 234, 237, 260, or 279.

SECTION 18. 16.53 (2) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.53 **(2)** IMPROPER INVOICES. If an agency receives an improperly completed invoice, the agency shall notify the sender of the invoice within 10 working days after it receives the invoice of the reason it is improperly completed. In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 233, 234, 237, 260, or 279.

SECTION 19. 16.54 (9) (a) 1. of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.54 **(9)** (a) 1. "Agency" means an office, department, independent agency, institution of higher education, association, society or other body in state

government created or authorized to be created by the constitution or any law, which is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 233, 234, 237, 260, or 279.

SECTION 20. 16.70 (2) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.70 **(2)** "Authority" means a body created under subch. II of ch. 114 or subch. III of ch. 149 or under ch. 231, 232, 233, 234, 235, 237, 260, or 279.

SECTION 21. 16.765 (1) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(1)** Contracting agencies, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Bradley Center Sports and Entertainment Corporation shall include in all contracts executed by them a provision obligating the contractor not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01 (5), sexual orientation as defined in s. 111.32 (13m), or national origin and, except with respect to sexual orientation, obligating the contractor to take affirmative action to ensure equal employment opportunities.

SECTION 22. 16.765 (2) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(2)** Contracting agencies, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin

Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Bradley Center Sports and Entertainment Corporation shall include the following provision in every contract executed by them: "In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01 (5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities. The contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause".

SECTION 23. 16.765 (4) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(4)** Contracting agencies, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Bradley Center Sports and Entertainment Corporation shall take appropriate action to revise the standard government contract forms under this section.

SECTION 24. 16.765 (5) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(5)** The head of each contracting agency and the boards of directors of the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Bradley Center Sports and Entertainment Corporation shall be primarily responsible for obtaining compliance by any contractor with the nondiscrimination and affirmative action provisions prescribed by this section, according to procedures recommended by the department. The department shall make recommendations to the contracting agencies and the boards of directors of the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, and the Bradley Center Sports and Entertainment Corporation for improving and making more effective the nondiscrimination and affirmative action provisions of contracts. The department shall promulgate such rules as may be necessary for the performance of its functions under this section.

SECTION 25. 16.765 (6) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(6)** The department may receive complaints of alleged violations of the nondiscrimination provisions of such contracts. The department shall investigate and determine whether a violation of this section has occurred. The department may delegate this authority to the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority,

the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation for processing in accordance with the department's procedures.

SECTION 26. 16.765 (7) (intro.) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(7)** (intro.) When a violation of this section has been determined by the department, the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation, the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation shall:

SECTION 27. 16.765 (7) (d) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(7)** (d) Direct the violating party to take immediate steps to prevent further violations of this section and to report its corrective action to the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation.

SECTION 28. 16.765 (8) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.765 **(8)** If further violations of this section are committed during the term of the contract, the contracting agency, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation may permit the violating party to complete the contract, after complying with this section, but thereafter the contracting agency, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation shall request the department to place the name of the party on the ineligible list for state contracts, or the contracting agency, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, the Lower Fox River Remediation Authority, or the Bradley Center Sports and Entertainment Corporation may terminate the contract without liability for the uncompleted portion or any materials or services purchased or paid for by the contracting party for use in completing the contract.

SECTION 29. 16.85 (2) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.85 **(2)** To furnish engineering, architectural, project management, and other building construction services whenever requisitions therefor are presented to the department by any agency. The department may deposit moneys received from the provision of these services in the account under s. 20.505 (1) (kc) or in the general

fund as general purpose revenue — earned. In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, which is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 233, 234, 237, 260, or 279.

SECTION 30. 16.865 (8) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

16.865 **(8)** Annually in each fiscal year, allocate as a charge to each agency a proportionate share of the estimated costs attributable to programs administered by the agency to be paid from the appropriation under s. 20.505 (2) (k). The department may charge premiums to agencies to finance costs under this subsection and pay the costs from the appropriation on an actual basis. The department shall deposit all collections under this subsection in the appropriation account under s. 20.505 (2) (k). Costs assessed under this subsection may include judgments, investigative and adjustment fees, data processing and staff support costs, program administration costs, litigation costs, and the cost of insurance contracts under sub. (5). In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 149 or in ch. 231, 232, 233, 234, 235, 237, 260, or 279.

SECTION 31. 20.855 (4m) of the statutes is created to read:

20.855 **(4m)** HEALTHY WISCONSIN PLAN. (s) *Healthy Wisconsin Authority.* From the Healthy Wisconsin trust fund, a sum sufficient to pay the Healthy Wisconsin Authority for the operation and funding of the Healthy Wisconsin Plan under ch. 260. Estimated disbursements under this paragraph shall not be included in the schedule under s. 20.005.

SECTION 32. 25.17 (1) (gd) of the statutes is created to read:

25.17 **(1)** (gd) Healthy Wisconsin trust fund (s. 25.775).

SECTION 33. 25.775 of the statutes is created to read:

25.775 Healthy Wisconsin trust fund. (1) There is established a separate, nonlapsible trust fund designated as the Healthy Wisconsin trust fund, consisting of all moneys appropriated or transferred to or deposited in the fund.

SECTION 34. 40.05 (4) (a) 4. of the statutes is created to read:

40.05 **(4)** (a) 4. This paragraph does not apply to any insured employee or retired insured employee who receives health care coverage under the Healthy Wisconsin Plan under ch. 260.

SECTION 35. 40.05 (4) (ag) (intro.) of the statutes is amended to read:

40.05 **(4)** (ag) (intro.) Beginning on January 1, 2004, except as otherwise provided in accordance with a collective bargaining agreement under subch. I or V of ch. 111 or s. 230.12 or 233.10, the employer shall pay for its currently employed insured employees who are not covered under the Healthy Wisconsin Plan under ch. 260:

SECTION 36. 40.05 (4) (ar) of the statutes is repealed.

SECTION 37. 40.05 (4) (b) of the statutes is amended to read:

40.05 **(4)** (b) Except as provided under pars. (bc) and (bp), accumulated unused sick leave under ss. 13.121 (4), 36.30, 230.35 (2), 233.10, and 757.02 (5) and subch.

I or V of ch. 111 of any eligible employee shall, at the time of death, upon qualifying for an immediate annuity or for a lump sum payment under s. 40.25 (1) or upon termination of creditable service and qualifying as an eligible employee under s. 40.02 (25) (b) 6. or 10., be converted, at the employee's highest basic pay rate he or she received while employed by the state, to credits for payment of health insurance premiums on behalf of the employee or the employee's surviving insured dependents. Any supplemental compensation that is paid to a state employee who is classified under the state classified civil service as a teacher, teacher supervisor, or education director for the employee's completion of educational courses that have been approved by the employee's employer is considered as part of the employee's basic pay for purposes of this paragraph. The full premium for any eligible employee who is insured at the time of retirement, or for the surviving insured dependents of an eligible employee who is deceased, shall be deducted from the credits until the credits are exhausted and paid from the account under s. 40.04 (10), and then deducted from annuity payments, if the annuity is sufficient. The department shall provide for the direct payment of premiums by the insured to the insurer if the premium to be withheld exceeds the annuity payment. Upon conversion of an employee's unused sick leave to credits under this paragraph or par. (bf), the employee or, if the employee is deceased, the employee's surviving insured dependents may initiate deductions from those credits or may elect to delay initiation of deductions from those credits, but only if the employee or surviving insured dependents are covered by a comparable health insurance plan or policy during the period beginning on the date of the conversion and ending on the date on which the employee or surviving insured dependents later elect to initiate deductions from those credits. If an employee or an employee's surviving insured dependents elect to delay initiation of deductions from

those credits, an employee or the employee's surviving insured dependents may only later elect to initiate deductions from those credits during the annual enrollment period under par. (be). A health insurance plan or policy is considered comparable if it provides hospital and medical benefits that are substantially equivalent to ~~the standard health insurance plan established under s. 40.52 (1)~~ benefits provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 38. 40.05 (4) (be) of the statutes is amended to read:

40.05 **(4)** (be) The department shall establish an annual enrollment period during which an employee or, if the employee is deceased, an employee's surviving insured dependents may elect to initiate or delay continuation of deductions from the employee's sick leave credits under par. (b). An employee or surviving insured dependent may elect to continue or delay continuation of such deductions any number of times. If an employee or surviving insured dependent has initiated the deductions but later elects to delay continuation of the deductions, the employee or surviving insured dependent must be covered by a comparable health insurance plan or policy during the period beginning on the date on which the employee or surviving insured dependent delays continuation of the deductions and ending on the date on which the employee or surviving insured dependent later elects to continue the deductions. A health insurance plan or policy is considered comparable if it provides hospital and medical benefits that are substantially equivalent to ~~the standard health insurance plan established under s. 40.52 (1)~~ benefits provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 39. 40.05 (4g) (d) of the statutes is created to read:

40.05 **(4g)** (d) This subsection shall not apply to an eligible employee who is receiving health care coverage under the Healthy Wisconsin Plan under ch. 260 while on active duty in the U.S. armed forces.

SECTION 40. 40.51 (1) of the statutes is amended to read:

40.51 **(1)** The procedures and provisions pertaining to enrollment, premium transmitted and coverage of eligible employees for health care benefits shall be established by contract or rule except as otherwise specifically provided by this chapter. Notwithstanding subs. (6) and (7), an eligible employee who is covered under the Healthy Wisconsin Plan under ch. 260 may not receive coverage under this subchapter for any coverage provided the employee under ch. 260.

SECTION 41. 40.51 (2) of the statutes is amended to read:

40.51 **(2)** Except as provided in subs. (10), (10m), (11) and (16), any eligible employee may become covered by group health insurance benefits under this subchapter by electing coverage within 30 days of being hired, to be effective as of the first day of the month which begins on or after the date the application is received by the employer, or by electing coverage prior to becoming eligible for any employer contribution towards the premium cost as provided in s. 40.05 (4) (a) to be effective upon becoming eligible for employer contributions. ~~An eligible employee who is not insured, but who is eligible for an employer contribution under s. 40.05 (4) (ag) 1., may elect coverage prior to becoming eligible for an employer contribution under s. 40.05 (4) (ag) 2., with the coverage to be effective upon becoming eligible for the increase in the employer contribution.~~ Any employee who does not so elect at one of these times, or who subsequently cancels the insurance, shall not thereafter become insured unless the employee furnishes evidence of insurability satisfactory to the insurer, at the employee's own expense or obtains coverage subject to contractual

waiting periods. The method to be used shall be specified in the health insurance contract.

SECTION 42. 40.51 (6) of the statutes is renumbered 40.51 (6) (a) and amended to read:

40.51 **(6)** (a) This state shall offer to all of its eligible employees described in subs. (10), (10m), and (16) at least 2 insured or uninsured health care coverage plans providing substantially equivalent hospital and medical benefits, including a health maintenance organization or a preferred provider plan, if those health care plans are ~~determined by the group insurance board to be available in the area of the place of employment and are~~ approved by the group insurance board. The group insurance board shall place each of the plans into one of 3 tiers established in accordance with standards adopted by the group insurance board. The tiers shall be separated according to ~~the employee's share of~~ premium costs.

SECTION 43. 40.51 (6) (b) of the statutes is created to read:

40.51 **(6)** (b) The state may offer to its employees coverage for health care benefits not provided to the employees under the Healthy Wisconsin Plan under ch. 260.

SECTION 44. 40.51 (7) of the statutes is amended to read:

40.51 **(7)** Any employer, other than the state, may offer to all of its employees ~~a health care coverage plan~~ coverage for health care benefits not provided to the employees under the Healthy Wisconsin Plan under ch. 260 through a program offered by the group insurance board. Notwithstanding sub. (2) and ss. 40.05 (4) and 40.52 (1), the department may by rule establish different eligibility standards or contribution requirements for such employees and employers and may by rule limit

the categories of employers, other than the state, which may be included as participating employers under this subchapter.

SECTION 45. 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) (a) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to ~~(5)~~ (6), 632.895 (5m) and (8) to (15), and 632.896.

SECTION 46. 40.51 (8m) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under ~~sub.~~ subs. (6) (b) and (7) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, and ~~632.895 (11) to (15)~~ 632.87 (3) to (6).

SECTION 47. 40.52 (1) (intro.) of the statutes is amended to read:

40.52 **(1)** (intro.) The group insurance board shall establish by contract a standard health insurance plan in which all insured employees shall participate except as otherwise provided in this chapter. ~~The~~ Except as provided in sub. (1m), the standard plan shall provide:

SECTION 48. 40.52 (1m) of the statutes is created to read:

40.52 **(1m)** The standard health insurance plan described under sub. (1) shall not provide employees any health care coverage that the employees receive under the Healthy Wisconsin Plan under ch. 260.

SECTION 49. 40.52 (2) of the statutes is amended to read:

40.52 **(2)** Health insurance benefits under this subchapter shall be integrated, with exceptions determined appropriate by the group insurance board, with benefits under federal plans for hospital and health care for the aged and disabled and with benefits provided under the Healthy Wisconsin Plan under ch. 260. Exclusions and limitations with respect to benefits and different rates may be established for persons eligible under federal plans for hospital and health care for the aged and disabled in recognition of the utilization by persons within the age limits eligible under the federal program and for employees who receive benefits under the Healthy Wisconsin Plan under ch. 260. The plan may include special provisions for spouses and other dependents covered under a plan established under this subchapter where one spouse is eligible under federal plans for hospital and health care for the aged or under the Healthy Wisconsin Plan under ch. 260 but the others are not eligible because of age or other reasons. As part of the integration, the department may, out of premiums collected under s. 40.05 (4), pay premiums for the federal health insurance.

SECTION 50. 40.98 (2) (a) 1. of the statutes is amended to read:

40.98 **(2)** (a) 1. The department shall design an actuarially sound health care coverage program for employers that includes more than one group health care coverage plan and that provides coverage beginning not later than January 1, 2001. The health care coverage program shall be known as the "Private Employer Health Care Purchasing Alliance". In designing the health care coverage program, the department shall consult with the office of the commissioner of insurance and may consult with the departments of commerce and health and family services. The health care coverage program may not be implemented until it is approved by the board. The health care coverage program shall not provide employees any health

care coverage that the employees receive under the Healthy Wisconsin Plan under ch. 260.

SECTION 51. 49.45 (54) of the statutes is created to read:

49.45 **(54)** ELIGIBILITY FOR HEALTHY WISCONSIN. (a) In this subsection, "program" means any Medical Assistance program administered under this subchapter.

(b) Notwithstanding any other statute to the contrary, if a program, or the provision of health care benefits for any eligibility category of persons under a program, is not eligible for, or supported by, federal matching funds, persons who are eligible for health care benefits under the program, or under the eligibility category under the program, are not eligible for those health care benefits but are instead eligible for coverage under the Healthy Wisconsin Plan under ch. 260.

SECTION 52. 49.473 (2) (c) of the statutes is amended to read:

49.473 **(2)** (c) The woman is not covered under the Healthy Wisconsin Plan under ch. 260 and is not eligible for any other health care coverage that qualifies as creditable coverage in 42 USC 300gg (c), excluding the coverage specified in 42 USC 300gg (c) (1) (F).

SECTION 53. 49.68 (3) (d) 1. of the statutes is amended to read:

49.68 **(3)** (d) 1. No aid may be granted under this subsection ~~unless~~ if the recipient has ~~no other form of~~ aid available from the federal ~~medicare~~ Medicare program, from private health, accident, sickness, medical, ~~and~~ or hospital insurance coverage, or from other health care coverage specified by rule under s. 49.687 (1m), excluding the Healthy Wisconsin Plan under ch. 260. If insufficient aid is available from other sources and if the recipient has paid an amount equal to the annual ~~medicare~~ Medicare deductible amount specified in subd. 2., the state shall pay the

difference in cost to a qualified recipient. If at any time sufficient federal or private insurance aid or other health care coverage becomes available during the treatment period, state aid under this subsection shall be terminated or appropriately reduced. Any patient who is eligible for the federal ~~medicare~~ Medicare program shall register and pay the premium for ~~medicare~~ Medicare medical insurance coverage where permitted, and shall pay an amount equal to the annual ~~medicare~~ Medicare deductible amounts required under 42 USC 1395e and 1395L (b), prior to becoming eligible for state aid under this subsection.

SECTION 54. 49.683 (3) of the statutes is amended to read:

49.683 **(3)** No payment shall be made under this section for any portion of medical care costs that are payable under any state, federal, or other health care coverage program, including a health care coverage program specified by rule under s. 49.687 (1m), or under any grant, contract, or other contractual arrangement, but excluding the Healthy Wisconsin Plan under ch. 260.

SECTION 55. 49.685 (6) (b) of the statutes is amended to read:

49.685 **(6)** (b) Reimbursement shall not be made under this section for any blood products or supplies that are not purchased from or provided by a comprehensive hemophilia treatment center, or a source approved by the treatment center. Reimbursement shall not be made under this section for any portion of the costs of blood products or supplies that are payable under any other state, federal, or other health care coverage program under which the person is covered, including a health care coverage program specified by rule under s. 49.687 (1m), or under any grant, contract, or other contractual arrangement, but excluding the Healthy Wisconsin Plan under ch. 260.

SECTION 56. 49.687 (1m) (d) of the statutes is created to read:

49.687 **(1m)** (d) Notwithstanding the health care programs for which a person must apply that are specified by the department by rule under pars. (a) and (b), a person is not ineligible to receive benefits under s. 49.68, 49.683, or 49.685 by reason of being eligible for or covered under the Healthy Wisconsin Plan under ch. 260.

SECTION 57. 59.52 (11) (c) of the statutes is amended to read:

59.52 **(11)** (c) *Employee insurance.* Provide for individual or group ~~hospital, surgical and~~ life insurance for county officers and employees and for payment of premiums for county officers and employees. A county may elect to provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 to its officers and employees and a county with at least 100 employees may elect to provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 on a self–insured basis to its officers and employees. A county and one or more cities, villages, towns, or other counties that together have at least 100 employees may jointly provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 to their officers and employees on a self–insured basis. Counties that elect to provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 on a self–insured basis to their officers and employees shall be subject to the requirements set forth under s. 120.13 (2) (c) to (e) and (g).

SECTION 58. 60.23 (25) of the statutes is amended to read:

60.23 **(25)** SELF–INSURED HEALTH PLANS. Provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 to its officers and employees on a self–insured basis, subject to s. 66.0137 (4).

SECTION 59. 62.61 of the statutes is renumbered 62.61 (1) (intro.) and amended to read:

62.61 **(1)** (intro.) The common council of a 1st class city may, by ordinance or resolution, ~~provide~~ do any of the following:

(a) Provide for, including the payment of premiums of, general hospital, surgical and group insurance for ~~both active and~~ retired city officers and city employees and their respective dependents in private companies~~, or may, by ordinance or resolution, elect~~.

(c) Elect to offer to all of its employees a health care coverage plan through a program offered by the group insurance board under ch. 40. Municipalities ~~which~~ that elect to participate under s. 40.51 (7) are subject to the applicable sections of ch. 40 instead of this section.

(2) Contracts for insurance under this section may be entered into for active officers and employees separately from contracts for retired officers and employees. Appropriations may be made for the purpose of financing insurance under this section. Moneys accruing to a fund to finance insurance under this section, by investment or otherwise, may not be diverted for any other purpose than those for which the fund was set up or to defray management expenses of the fund or to partially pay premiums to reduce costs to the city or to persons covered by the insurance, or both.

SECTION 60. 62.61 (1) (b) of the statutes is created to read:

62.61 **(1)** (b) Subject to s. 260.37, provide for, including the payment of premiums of, group health insurance for active city officers and city employees and their respective dependents.

SECTION 61. 66.0137 (4) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

66.0137 **(4)** SELF–INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 under its home rule power, or if a town provides health care benefits not provided under the Healthy Wisconsin Plan under ch. 260, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) ~~and (5)~~, 632.895 ~~(9) to~~ (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 62. 66.0137 (4m) (b) of the statutes is amended to read:

66.0137 **(4m)** (b) A political subdivision and one or more other political subdivisions, that together have at least 100 employees, may jointly provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 to their officers and employees on a ~~self insured~~ self–insured basis.

SECTION 63. 66.0137 (5) of the statutes is amended to read:

66.0137 **(5)** HOSPITAL, ACCIDENT, AND LIFE INSURANCE. ~~The~~ Subject to s. 260.37, the state or a local governmental unit may provide for the payment of premiums for ~~hospital, surgical and other~~ health and accident insurance and life insurance for employees and officers and their spouses and dependent children. A local governmental unit may also provide for the payment of premiums for hospital and surgical care for its retired employees. In addition, a local governmental unit may, by ordinance or resolution, elect to offer to all of its employees a health care coverage plan through a program offered by the group insurance board under ch. 40. A local governmental unit that elects to participate under s. 40.51 (7) is subject to the applicable sections of ch. 40 instead of this subsection.

SECTION 64. 70.11 (41p) of the statutes is created to read:

70.11 **(41p)** HEALTHY WISCONSIN AUTHORITY. All property owned by the Healthy Wisconsin Authority, provided that use of the property is primarily related to the purposes of the authority.

SECTION 65. 71.26 (1) (be) of the statutes is amended to read:

71.26 **(1)** (be) *Certain authorities.* Income of the University of Wisconsin Hospitals and Clinics Authority, of the Health Insurance Risk–Sharing Plan Authority, ~~and~~ of the Healthy Wisconsin Authority, of the Fox River Navigational System Authority, and of the Wisconsin Aerospace Authority.

SECTION 66. 77.54 (9a) (a) of the statutes is amended to read:

77.54 **(9a)** (a) This state or any agency thereof, the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Health Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, and the Fox River Navigational System Authority.

SECTION 67. 100.45 (1) (dm) of the statutes is amended to read:

100.45 **(1)** (dm) "State agency" means any office, department, agency, institution of higher education, association, society or other body in state government created or authorized to be created by the constitution or any law which is entitled to expend moneys appropriated by law, including the legislature and the courts, the Wisconsin Housing and Economic Development Authority, the Bradley Center Sports and Entertainment Corporation, the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Health and Educational Facilities Authority, the Wisconsin Aerospace Authority, ~~and~~ the Fox River Navigational System Authority, and the Healthy Wisconsin Authority.

SECTION 68. 109.075 (9) of the statutes is created to read:

109.075 **(9)** This section does not apply to an employer that ceases providing health care benefits to its employees because the employees are covered under the Healthy Wisconsin Plan under ch. 260.

SECTION 69. 111.70 (1) (dm) of the statutes is amended to read:

111.70 **(1)** (dm) "Economic issue" means salaries, overtime pay, sick leave, payments in lieu of sick leave usage, vacations, clothing allowances in excess of the actual cost of clothing, length–of–service credit, continuing education credit, shift premium pay, longevity pay, extra duty pay, performance bonuses, health insurance coverage of benefits not provided under the Healthy Wisconsin Plan under ch. 260, life insurance, dental insurance, disability insurance, vision insurance, long–term care insurance, worker's compensation and unemployment insurance, social security benefits, vacation pay, holiday pay, lead worker pay, temporary assignment pay, retirement contributions, supplemental retirement benefits, severance or other separation pay, hazardous duty pay, certification or license payment, limitations on layoffs that create a new or increased financial liability on the employer and contracting or subcontracting of work that would otherwise be performed by municipal employees in the collective bargaining unit with which there is a labor dispute.

SECTION 70. 111.70 (4) (cm) 8s. of the statutes is amended to read:

111.70 **(4)** (cm) 8s. 'Forms for determining costs.' The commission shall prescribe forms for calculating the total increased cost to the municipal employer of compensation and fringe benefits provided to school district professional employees. The cost shall be determined based upon the total cost of compensation and fringe benefits provided to school district professional employees who are represented by a labor organization on the 90th day before expiration of any previous collective

bargaining agreement between the parties, or who were so represented if the effective date is retroactive, or the 90th day prior to commencement of negotiations if there is no previous collective bargaining agreement between the parties, without regard to any change in the number, rank or qualifications of the school district professional employees. For purposes of such determinations, any cost increase that is incurred on any day other than the beginning of the 12–month period commencing with the effective date of the agreement or any succeeding 12–month period commencing on the anniversary of that effective date shall be calculated as if the cost increase were incurred as of the beginning of the 12–month period beginning on the effective date or anniversary of the effective date in which the cost increase is incurred. For the purpose of determining if a municipal employer has maintained current fringe benefits under sub. (1) (nc) 1. a., the commission shall consider the municipal employer to have maintained its health care coverage benefit if the municipal employer provides health care coverage to its school district professional employees through the Healthy Wisconsin Plan under ch. 260 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 Plan under ch. 260. 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 shall be resolved by a neutral person who is designated by the commission. In each collective bargaining unit to which subd. 5s. applies, the municipal employer shall transmit to the commission and the labor organization a completed form for calculating the total increased cost to the municipal employer of compensation and fringe benefits provided to the school

district professional employees covered by the agreement as soon as possible after the effective date of the agreement.

SECTION 71. 111.91 (2) (pt) of the statutes is created to read:

111.91 **(2)** (pt) Health care coverage of employees under the Healthy Wisconsin Plan under ch. 260.

SECTION 72. 120.13 (2) (b) of the statutes is amended to read:

120.13 **(2)** (b) Provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 on a self–insured basis to the employees of the school district if the school district has at least 100 employees. In addition, any 2 or more school districts which together have at least 100 employees may jointly provide health care benefits not provided under the Healthy Wisconsin Plan under ch. 260 on a self–insured basis to employees of the school districts.

SECTION 73. 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) ~~and (5)~~, 632.895 ~~(9) to~~ (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 74. 149.12 (2) (em) of the statutes is created to read:

149.12 **(2)** (em) No person who is eligible for coverage under the Healthy Wisconsin Plan under ch. 260 is eligible for coverage under the plan under this chapter.

SECTION 75. 230.03 (3) of the statutes, as affected by 2007 Wisconsin Act 20, is amended to read:

230.03 **(3)** "Agency" means any board, commission, committee, council, or department in state government or a unit thereof created by the constitution or statutes if such board, commission, committee, council, department, unit, or the head thereof, is authorized to appoint subordinate staff by the constitution or statute, except a legislative or judicial board, commission, committee, council, department, or unit thereof or an authority created under subch. II of ch. 114 or subch. III of ch. 149 or under ch. 231, 232, 233, 234, 235, 237, 260, or 279. "Agency" does not mean any local unit of government or body within one or more local units of government that is created by law or by action of one or more local units of government.

SECTION 76. Chapter 260 of the statutes is created to read:

CHAPTER 260

HEALTHY WISCONSIN PLAN

260.01 Definitions. In this chapter, except as otherwise provided:

(1) "Authority" means the Healthy Wisconsin Authority.

(2) "Board" means the board of trustees of the authority.

(3) "Health care network" means a provider–driven, coordinated group of health care providers comprised of primary care physicians, medical specialists, physician assistants, nurses, clinics, one or more 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.

(4) "Medical inflation" means changes in the consumer price index for all consumers, U.S. city average, for the medical care group, including medical care commodities and medical care services, as determined by the U.S. department of labor.

(5) "Plan" means the Healthy Wisconsin Plan.

(6) "Primary care provider" means a health care provider who is identified as the key professional responsible for coordinating all medical care for a given participant, including referral to a specialist. "Primary care provider" includes general practice physicians, family practitioners, internists, pediatricians, obstetricians and gynecologists, advanced practice nurses, certified nurse midwives, and physician assistants. "Primary care provider" may also include a specialist who is treating a person with a chronic medical condition or special health care needs for which regular treatment by a specialist is medically necessary or a specialist who is treating a disabled person.

260.05 Creation and organization of authority. (1) CREATION AND MEMBERSHIP OF BOARD. There is created a public body corporate and politic to be known as the "Healthy Wisconsin Authority." The nonvoting members of the board shall consist of the secretary of employee trust funds and 4 representatives from the advisory committee under s. 260.49 who are health care personnel and administrators, selected by the advisory committee. The secretary of employee trust funds shall serve as the initial chairperson of the board until such time as the board elects a chairperson from its voting membership. The board shall also consist of the following voting members, nominated by the governor and with the advice and consent of the senate appointed, for staggered 6–year terms:

(a) Four members selected from a list of names submitted by statewide labor or union coalitions. One of these members shall be a public employee.

(b) Four members selected from a list of names submitted by statewide business and employer organizations. One of these members shall be a public employer.

(c) One member selected from a list of names submitted by statewide public school teacher labor organizations.

(d) One member selected from a list of names submitted by statewide small business organizations.

(e) Two members who are farmers, selected from a list of names submitted by statewide general farm organizations.

(f) One member who is a self–employed person.

(g) Three members selected from a list of names submitted by statewide health care consumer organizations.

(2) TERMS OF OFFICE; VACANCIES; QUORUM; BUSINESS. (a) The terms of all members of the board shall expire on July 1.

(b) Each member of the board shall hold office until a successor is appointed and qualified unless the member vacates or is removed from his or her office. A member who serves as a result of holding another office or position vacates his or her office as a member when he or she vacates the other office or position. A member who ceases to qualify for office vacates his or her office. A vacancy on the board shall be filled in the same manner as the original appointment to the board for the remainder of the unexpired term, if any.

(c) A majority of the members of the board constitutes a quorum for the purpose of conducting its business and exercising its powers and for all other purposes, notwithstanding the existence of any vacancies. Action may be taken by the board upon a vote of a majority of the members present. Meetings of the members of the board may be held anywhere within or without the state.

(3) BOARD MEMBER RESPONSIBILITY AS TRUSTEE. Each member of the board shall be responsible for taking care that the highest level of independence and judgment

is exercised at all times in administering the plan and overseeing the individuals and organizations selected to implement the plan.

(4) DUTIES. The board shall:

(a) 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 establishing and administering the health care system, except as otherwise provided by law, the board shall seek to attain all of the following goals:

1. Every resident of this state shall have access to affordable, comprehensive health care services.

2. Health care reform shall maintain and improve choice of health care providers and high quality health care services in this state.

3. Health care reform shall implement cost containment strategies that retain and assure affordable coverage for all residents of this state.

(b) Establish, fund, and manage the plan as provided in this chapter.

(c) Appoint an executive director, who shall serve at the pleasure of the board. The board may delegate to one or more of its members or its executive director any powers and duties the board considers proper. The executive director shall receive such compensation as may be determined by the board.

(d) Provide for mechanisms to enroll every eligible resident in this state under the plan. Contracts entered into by the board with providers shall include provisions to enroll all eligible persons at the point of service, and outreach programs to assure every eligible person becomes enrolled in the plan.

(e) Create a program for consumer protection and a process to resolve disputes with providers.

(f) 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.

(g) Submit an annual report on its activities to the governor and chief clerk of each house of the legislature, for distribution under s. 13.172 (2).

(h) Contract for annual, independent, program evaluations and financial audits that measure the extent to which the plan is achieving the goals under par. (a) 1. to 3. The board may not enter into a contract with the same auditor for more than 6 years.

(i) Accept bids from health care networks in accordance with the criteria set out in s. 260.30, or make payments to fee–for–service providers in accordance with s. 260.30. The board shall consult with the department of employee trust funds in determining the most effective and efficient way of purchasing health care benefits.

(j) Audit health care networks and providers to determine if their services meet the plan objectives and criteria under this chapter.

(5) POWERS. The board shall have all the powers necessary or convenient to carry out the purposes and provisions of this chapter. In addition to all other powers granted the board under this chapter, the board may:

(a) Adopt, amend, and repeal bylaws and policies and procedures for the regulation of its affairs and the conduct of its business.

(b) Have a seal and alter the seal at pleasure.

(c) Maintain an office.

(d) Sue and be sued.

(e) Accept gifts, grants, loans, or other contributions from private or public sources.

(f) Establish the authority's annual budget and monitor the fiscal management of the authority.

(g) Execute contracts and other instruments, including contracts for any professional services required for the authority.

(h) Employ any officers, agents, and employees that it may require and determine their qualifications and compensation.

(i) Procure liability insurance.

(j) Contract for studies on issues, as identified by the board or by the advisory committee under s. 260.49, that relate to the plan.

(k) Borrow money, as necessary on a short–term basis, to address cash flow issues.

(L) Compel witnesses to attend meetings and to testify upon any necessary matter concerning the plan.

260.10 Eligibility. (1) COVERED PERSONS. Except as provided in subs. (2) to (5) and subject to sub. (6), a person is eligible to participate in the plan if the person satisfies all of the following criteria:

(a) The person has maintained his or her place of permanent abode, as defined by the board, in this state for at least 12 months.

(b) The person maintains a substantial presence in this state, as defined by the board.

(c) The person is under 65 years of age.

(d) The person is not eligible for health care coverage from the federal government or a foreign 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.

(e) Subject to s. 49.45 (54), unless a waiver requested under sub. (6) (b) has been granted and is in effect, the person is not eligible for Medical Assistance under subch. IV of ch. 49, including for health care coverage under BadgerCare Plus.

(2) GAINFULLY EMPLOYED. If a person and the members of the person's immediate family do not meet the criteria under sub. (1) (a) and (b), but do meet the criteria under sub. (1) (c) to (e) and 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.

(3) DEPENDENT 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 under sub. (1) (a), the child is eligible to participate in the plan regardless of the length of time the child has resided in this state, if the child meets the criteria under sub. (1) (b) to (e).

(4) PREGNANT WOMEN. A pregnant woman who resides in this state who does not yet meet the residency requirement under sub. (1) (a) is eligible to participate in the plan regardless of the length of time the pregnant woman has resided in this state, if she meets the criteria under sub. (1) (b) to (e).

(5) COLLECTIVE BARGAINING AGREEMENT. A person who is eligible to participate in the plan under sub. (1), (2), (3), or (4) and who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2010, 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.

(6) WAIVER REQUEST. (a) In this subsection, "department" means the department of health and family services.

(b) 1. The department shall develop a request for a waiver from the secretary of the federal department of health and human services to provide coverage under the plan to individuals who are eligible for Medical Assistance under subch. IV of ch. 49 in the low–income families category, as determined by the department, including individuals who are eligible for health care coverage under BadgerCare Plus. The waiver request shall be written so as to allow the use of federal financial participation to fund, to the maximum extent possible, health care coverage under the plan for the individuals specified in this subdivision.

2. The department shall, not later than July 1, 2009, submit the waiver request developed under subd. 1. to a special legislative committee that shall be comprised of the members of the joint committee on finance and the members of the standing committees of the senate and the assembly with subject matter jurisdiction over health issues. The special legislative committee shall have 60 days to review and comment to the department on the waiver request.

(c) Except as required under par. (b), the department may develop waiver requests to the appropriate federal agencies to permit funds from federal health care services programs to be used for health care coverage for persons under the plan.

(7) DEFINITIONS OF TERMS. For purposes of this chapter, the board shall define all of the following terms:

(a) Place of permanent abode.

(b) Substantial presence this state. In defining "substantial presence in this state," the board shall consider such factors as the amount of time per year that an individual is actually present in the state and the amount of taxes that an individual

pays in this state, except that, if the individual attends school outside of this state and is under 23 years of age, the factors shall include the amount of time that the individual's parent or guardian is actually present in the state and the amount of taxes that the individual's parent or guardian pays in this state, and if the individual is in active service with the U.S. armed forces outside of this state, the factors shall include the amount of time that the individual's parent, guardian, or spouse is actually present in the state and the amount of taxes that the individual's parent, guardian, or spouse pays in this state.

(c) Immediate family.

(d) Gainfully employed. The definition shall include employment by persons who are self–employed and persons who work on farms.

260.12 Office of outreach, enrollment, and advocacy. (1) ESTABLISHMENT. The board shall establish an office of outreach, enrollment, and advocacy. The office shall contract with nonprofit organizations to perform the outreach, enrollment, and advocacy functions specified in this section, and to review the health care payment and services records of persons who are participating, or who are eligible to participate, in the plan and who have provided the office with informed consent for the review. The office may not contract with any organization under this subsection that provides services under the plan or that has any other conflict of interest, as described in sub. (3).

(2) DUTIES. The office of outreach, enrollment, and advocacy shall do all of the following:

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

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

(c) 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.

(d) At the direction of the board, establish a process for resolving disputes with providers.

(e) 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. Investigation should include, when appropriate, consulting with the health care advisory committee under s. 260.49 regarding best practice guidelines.

(f) 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.

(g) 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 under s. 260.49, make recommendations for resolving those problems and concerns.

(h) Ensure that plan participants have timely access to the services provided by the office.

(3) CONFLICT OF INTEREST LIMITATION. The office and its employees and contractors shall not have any conflict of interest relating to the performance of their duties. There is a conflict of interest if, with respect to the office's director, employees, or contractors, or a person affiliated with the office's director, employees, or contractors, any of the following exists:

(a) Direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or health care provider.

(b) Direct ownership interest or investment interest in a health care facility, health insurer, or health care provider.

(c) Employment by, or participation in, the management of a health care facility, health insurer, or health care provider.

(d) Receipt of, or having the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

260.15 Benefits. (1) GENERALLY. The board shall establish a health care plan that will take effect on January 1, 2010. The plan shall provide the same benefits as those that were in effect as of January 1, 2008, under the state employee health plan under s. 40.51 (6), 2005 stats. 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.

(2) ADDITIONAL BENEFITS. In addition to the benefit requirements under sub. (1), the plan shall provide coverage for mental health services and alcohol and 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.

260.20 Cost sharing. (1) NO COST SHARING. The plan shall cover the following preventive services without any cost–sharing requirement:

(a) Prenatal care for pregnant women.

(b) Well–baby care.

(c) Medically appropriate examinations and immunizations for children up to 18 years of age.

(d) Medically appropriate gynecological exams, Papanicolaou tests, and mammograms.

(e) Medically appropriate regular medical examinations for adults, as determined by best practices.

(f) Medically appropriate colonoscopies.

(g) Preventive dental care for children up to 18 years of age.

(h) 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.

(i) 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.

(2) DEDUCTIBLES. (a) *Maximum amounts and who must pay.* 1. Subject to subd. 2., during any year, a participant who is 18 years of age or older on January 1 of that year shall pay a deductible of $300, which shall apply to all covered services and articles.

2. During any year, a family consisting of 2 or more participants who are 18 years of age or older on January 1 of that year shall pay a deductible of $600, which shall apply to all covered services and articles.

3. During any year, a participant who is under 18 years of age on January 1 of that year shall not be required to pay a deductible.

4. 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 under this paragraph, regardless of whether the participant has paid the deductible amount.

(b) *Provider requirements.* 1. A provider that provides to a participant a covered service or article to which a deductible applies shall charge for the service or article the payment rate established by the board under s. 260.30 (7) (b) 1. if the participant's coverage is under the fee–for–service option under s. 260.30 (2) (a) or the applicable network rate for the service or article, as determined by the board, if the participant's coverage is under the health care network option under s. 260.30 (2) (b). Except as provided in subd. 3., a provider of a covered service or article to which a deductible applies shall accept as payment in full for the covered service or article the payment rate specified in this subdivision and may not bill a participant who receives the service or article for any amount by which the charge for the service or article is reduced under this subdivision.

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

3. A provider may not charge any interest, penalty, or late fee on any deductible amount owed by a participant unless the deductible amount owed is at least 6 months past due and the provider has provided the participant with notice of the

interest, penalty, or late fee at least 90 days before the interest, penalty, or late fee payment is due. Interest may not exceed 1 percent per month, and any penalty or late fee may not exceed the provider's reasonable cost of administering the unpaid bill.

(c) *Adjustments by board.* Notwithstanding par. (a) 1. and 2., the board may adjust the deductible amounts specified in par. (a) 1. and 2., but only to reduce those amounts.

(3) COPAYMENTS AND COINSURANCE. (a) *General copayments.* During any year, a participant who is 18 years of age or older on January 1 of that year shall pay a copayment of $20 for medical, hospital, and related health care services, as determined by the board.

(b) *Specialist provider services without referral.* 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 shall be required to pay 25 percent of the cost of the services provided.

(c) *Inappropriate emergency room use.* Notwithstanding par. (a), a participant who is 18 years of age or older shall pay a copayment of $60 for inappropriate emergency room use, as determined by the board.

(d) *Prescription drugs.* 1. All participants, regardless of age, shall pay $5 for each prescription of a generic drug that is on the formulary determined by the board.

2. All participants, regardless of age, shall pay $15 for each prescription of a brand–name drug that is on the formulary determined by the board.

3. All participants, regardless of age, shall pay $40 for each prescription of a brand–name drug that is not on the formulary determined by the board.

4. Notwithstanding subds. 1. to 3., no participant shall pay more for a prescription drug than the actual cost of the prescription drug plus the negotiated dispensing fee.

(e) *Adjustments by board.* Notwithstanding pars. (a) to (d), the board may adjust the copayment and coinsurance amounts specified in pars. (a) to (d).

(4) MAXIMUM AMOUNTS. Notwithstanding the deductible, coinsurance, and copayment amounts in subs. (2) and (3), all of the following apply:

(a) Subject to par. (b), a participant who is 18 years of age or older on January 1 of a year may not be required to pay more than $2,000 during that year in total cost sharing under subs. (2) and (3).

(b) A family consisting of 2 or more participants may not be required to pay more than $3,000 during a year in total cost sharing under subs. (2) and (3).

260.30 Service areas; selection and payment of health care providers and health care networks. (1) ESTABLISHMENT OF AREAS WHERE SERVICES WILL BE PROVIDED. The board may establish areas in the state, which may be counties, multicounty regions, or other areas, for the purpose of receiving bids from health care networks. These areas shall be established so as to maximize the level and quality of competition among health care networks or to increase the number of provider choices available to eligible persons and participants in the areas.

(2) OPTIONS AVAILABLE IN EACH AREA. In each area designated by the board under sub. (1), the board shall offer both of the following options for delivery of health care services under the plan:

(a) An option, known as the "fee–for–service option," under which 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 this chapter. Under this option, the board, with the assistance of one or more administrators chosen by a competitive bidding process and with whom the board has contracted, shall pay directly, at the provider payment rates established by the board under sub. (7) (b) 1., for all health care services and articles that are covered under the plan.

(b) An option under which one or more health care networks that meet the qualifying criteria in sub. (4) and are certified under sub. (5) provide health care services to participants. The board is required to offer this option in each area designated by the board to the extent that qualifying health care networks exist in the area.

(3) SOLICITATION OF BIDS FROM HEALTH CARE NETWORKS. The board shall annually solicit sealed risk–adjusted premium bids from competing health care networks for the purpose of offering health care coverage to participants. The board shall request each bidder to submit information pertaining to whether the bidder is a qualifying health care network, as described in sub. (4).

(4) QUALIFYING HEALTH CARE NETWORKS. A health care network is qualifying if it does all of the following:

(a) Demonstrates to the satisfaction of the board that the fixed monthly risk–adjusted amount that it bids to provide participants with the health care benefits specified in this chapter reasonably reflects its estimated actual costs for providing participants with such benefits in light of its underlying efficiency as a network, and has not been artificially underbid for the predatory purpose of gaining market share.

(b) Will spend at least 92 percent of the revenue it receives under this chapter on one of the following:

1. Payments to health care providers in order to provide the health care benefits specified in this chapter to participants who choose the health care network.

2. Investments that the health care network has reasonably determined will improve the overall quality or lower the overall cost of patient care.

(c) Ensures all of the following:

1. That participants living in an area that the health care network serves shall 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 2 primary care providers, as defined by the board.

2. 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 and other drug abuse treatment, are conveniently available, as defined by the board, to participants living in every part of the area that the health care network serves.

(d) 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 provided under this chapter and the choices of providers that participants have in using the health care network.

(e) 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.

(f) 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.

(g) Emphasizes, in its policies and operations, the promotion of healthy lifestyles; preventive care, including early identification of and response to high–risk individuals and groups, early identification of and response to health disorders, disease management, including chronic care management, and 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.

(h) 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.

(i) 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 level of cost sharing, the services of out–of–network providers that the network's primary care physicians selected by participants have determined is 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.

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

(k) Has adopted and implemented a strong policy to safeguard against conflicts of interest.

(L) 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.

(m) Agrees to enroll and provide the benefits specified in this chapter to all participants who choose the health care 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:

1. 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 benefits specified in this chapter 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.

2. Limit the participants that it serves to a specific affinity group, 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 described in this paragraph and has neither been created for the purpose, nor will have the effect, of screening out higher–risk enrollees. This subdivision applies only to affinity groups that are in existence as of December 31, 2008.

(5) CERTIFICATION OF HEALTH CARE NETWORKS AND CLASSIFICATION OF BIDS. (a) The board shall review the bids submitted under sub. (3), the information submitted by

bidders pertaining to whether the bidders are qualifying health care networks, and other evidence provided to the board as to whether a particular bidder is a qualifying health care network.

(b) Based on the information about bidder qualification submitted or otherwise provided under par. (a), the board shall certify which health care networks are qualifying health care networks.

(c) With respect to all health care networks that the board certifies under par. (b), the board shall open the submitted, sealed bids at a predetermined time. The board shall classify the certified health care networks according to price and quality measures after comparing their risk–adjusted per–month bids and assessing their quality. The board shall classify the network that bid the lowest price as the lowest–cost network, and shall classify as a low–cost network any network that has bid a price that is close to the price bid by the lowest–cost network. Any other network shall be classified as a higher–cost network.

(6) OPEN ENROLLMENT. The board shall provide an annual open enrollment period during which each participant may select a certified health care network from among those offered, or a fee–for–service option. Coverage shall be effective on the following January 1. A participant who does not select a certified health care network or the fee–for–service option will be assigned randomly to one of the networks that have been classified under sub. (5) as having submitted the lowest or a low bid and as performing well on quality measures, or to the fee–for–service option if that is the lowest–cost option. A participant who selects the fee–for–service option or a certified health care network that has been classified as a higher–cost network, but who fails to pay the additional payment under sub. (7) (a) 2., shall be assigned randomly to one of the networks that has been classified under sub. (5) as the

lowest–cost network or as a low–cost network and as performing well on quality measures, or to the fee–for–service option if that is the lowest–cost option.

(7) PAYMENTS TO NETWORKS AND PROVIDERS. (a) *Payments to health care networks.* 1. On behalf of each participant who selects or has been assigned to a certified health care network that has been classified under sub. (5) (c) as the lowest–cost network or a low–cost network and as performing well on quality measures, the board shall pay monthly to the health care network the full risk–adjusted per–member per–month amount that was bid by the network. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who selects or is assigned to the lowest–cost network or a low–cost network shall not be required to pay any additional amount to the network.

2. If a participant chooses instead to enroll in a certified health care network that has been classified under sub. (5) (c) as a higher–cost network, the board shall pay monthly to the chosen health care network an amount equal to the bid submitted by the network that the board classified under sub. (5) (c) as the lowest–cost network and as having performed well on quality measures. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who chooses to enroll in a higher–cost network shall be required to pay monthly, in addition to the amount paid by the board, an amount sufficient to ensure that the chosen network receives the full price bid by that network.

3. The board may retain a percentage of the dollar amounts established for each participant under subds. 1. and 2. to pay to certified health care networks that have incurred disproportionate risk not fully compensated for by the actuarial adjustment

in the amount established for each eligible person. Any payment to a certified health care network under this subdivision shall reflect the disproportionate risk incurred by the health care network.

(b) *Payments to fee–for–service providers.* 1. The board shall 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 under sub. (2) (a). The payment rates shall be fair and adequate to ensure that this state is able to retain the highest quality of medical practitioners. The board shall 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.

2. Except for deductibles, copayments, coinsurance, and any other cost sharing required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under subd. 1. and may not bill a participant who receives the service or article for any amount by which the charge for the service or article is reduced under subd. 1.

3. The board, with the assistance of its actuarial consultants, shall establish the monthly risk–adjusted cost of the fee–for–service option offered to participants under sub. (2) (a). The board shall classify the fee–for–service option in the same manner as the board classifies certified health care networks under sub. (5) (c).

4. If the board has determined under sub. (5) (c) that there is at least one certified low–cost health care network in an area, which may be the lowest–cost health care network, and if the fee–for–service option offered in that area has been classified as a higher–cost choice under subd. 3., the cost to a participant enrolling in the fee–for–service option shall be determined as follows:

a. If there are available to the participant 3 or more certified health care networks classified under sub. (5) (c) as low–cost networks, or as the lowest–cost network and 2 or more low–cost networks, the participant shall pay the difference between the cost of the lowest–cost health care network and the monthly risk–adjusted cost established under subd. 3. for the fee–for–service option, except that the amount paid may not exceed $100 per month for an individual, or $200 per month for a family, as adjusted for medical inflation.

b. If there are available to the participant 2 certified health care networks classified under sub. (5) (c) as low–cost networks, or as the lowest–cost network and one low–cost network, the participant shall pay the difference between the cost of the lowest–cost health care network and the monthly risk–adjusted cost established under subd. 3. for the fee–for–service option, except that the amount paid may not exceed $65 per month for an individual, or $125 per month for a family, as adjusted for medical inflation.

c. If there is available to the participant only one certified health care network classified under sub. (5) (c) as a low–cost network, or as the lowest–cost network, the person shall pay the difference between the cost of the lowest–cost health care network and the monthly risk–adjusted cost established under subd. 3. 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.

5. If the board has determined, under sub. (5) (c), that there is no certified lowest–cost health care network or low–cost health care network in the area, there shall be no extra cost to the participant enrolling in the fee–for–service option.

(8) INCENTIVE PAYMENTS TO FEE–FOR–SERVICE PROVIDERS. Health care providers and facilities providing services under the fee–for–service option under sub. (2) (a)

shall be encouraged to collaborate with each other through financial incentives established by the board. Providers shall work with facilities to pool infrastructure and resources; to implement the use of best practices and quality measures; and to establish organized processes that will result in high–quality, low–cost medical care. The board shall establish an incentive payment system to providers and facilities that comply with this subsection, in accordance with criteria established by the board.

(9) PHARMACY BENEFIT. Except for prescription drugs to which a deductible applies, the board shall assume the risk for, and pay directly for, prescription drugs provided to participants. In implementing this requirement, the board shall replicate the prescription drug buying system developed by the group insurance board for prescription drug coverage under the state employee health plan under s. 40.51 (6), unless the board determines that another approach would be more cost–effective. The board may join the prescription drug purchasing arrangement under this chapter with similar arrangements or programs in other states to form a multistate purchasing group to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices, or to contract with a 3rd party, such as a private pharmacy benefits manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

260.35 Subrogation. The board and authority are entitled to the right of subrogation for reimbursement to the extent that a participant may recover reimbursement for health care services and items in an action or claim against any 3rd party.

260.37 Employer–provided health care benefits. Nothing in this chapter prevents an employer, or a Taft–Hartley trust on behalf of an employer, from paying

all or part of any cost sharing under s. 260.20 or 260.30, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

260.40 Assessments, individuals and businesses. (1) DEFINITIONS. In this section:

(a) "Department" means the department of revenue.

(b) "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full–time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(c) "Eligible individual" means an individual who is eligible to participate in the plan, other than an employee or a self–employed individual.

(d) "Employee" means an individual who has an employer.

(e) "Employer" means a person who is required under the Internal Revenue Code to file form 941.

(em) "Household" means an individual who is either an eligible individual, an employee, or a self–employed individual, and the individual's immediate family, as that term is defined by the board under s. 260.10 (7) (c).

(f) "Medical inflation" means the percentage change between the U.S. consumer price index for all urban consumers, U.S. city average, for the medical care group only, including medical care commodities and medical care services, for the month of August of the previous year and the U.S. consumer price index for all urban consumers, U.S. city average, for the medical care group only, including medical care commodities and medical care services, for the month of August 2008, as determined by the U.S. department of labor.

(g) "Poverty line" means the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family.

(h) "Self–employed individual" means an individual who is required under the Internal Revenue Code to file schedule SE.

(i) "Small employer" means an employer who has no more than 10 employees.

(j) "Social security wages" means:

1. For purposes of sub. (2) (a), the amount of wages, as defined in section 3121 (a) of the Internal Revenue Code, paid to an employee by an employer in a taxable year, up to a maximum amount that is equal to the social security wage base.

2. For purposes of sub. (2) (b), the amount of net earnings from self–employment, as defined in section 1402 (a) of the Internal Revenue Code, received by an individual in a taxable year, up to a maximum amount that is equal to the social security wage base.

3. For purposes of sub. (3), the amount of wages, as defined in section 3121 (a) of the Internal Revenue Code, paid by an employer in a taxable year with respect to employment, as defined in section 3121 (b) of the Internal Revenue Code, up to a maximum amount that is equal to the social security wage base multiplied by the number of the employer's employees.

(2) INDIVIDUALS. Subject to sub. (4), the board shall calculate the following assessments, based on its anticipated revenue needs:

(a) For an employee who is under the age of 65, a percent of social security wages that is at least 2 percent and not more than 4 percent, subject to the following:

1. If the employee has social security wages that are 150 percent or less of the poverty line, the employee may not be assessed.

2. If the employee has no dependents and his or her social security wages are more than 150 percent and 200 percent or less 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 zero percent and 4 percent 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 percent and 300 percent or less 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 zero percent and 4 percent of the employee's social security wages.

(b) For a self–employed individual who is under the age of 65, a percent of social security wages that is at least 9 percent and not more than 10 percent.

(c) For an eligible individual who has no social security wages under sub. (1) (j) 1. or 2. or, from an employer, under sub. (1) (j) 3., 10 percent of federal adjusted gross income, up to the maximum amount of income that is subject to social security tax.

(3) EMPLOYERS. (a) Subject to pars. (b), (c), and (d) and sub. (4), the board shall calculate an assessment, based on its anticipated revenue needs, that is a percent of aggregate social security wages that is at least 9 percent and not more than 12 percent.

(b) Except as provided in par. (d), for taxable year beginning after December 31, 2009, and before January 1, 2011, the assessment imposed on a small employer shall be 33 percent of the amount calculated for that employer under par. (a).

(c) Except as provided in par. (d), for taxable year beginning after December 31, 2010, and before January 1, 2012, the assessment imposed on a small employer shall be 67 percent of the amount calculated for that employer under par. (a).

(d) If a small employer begins doing business in this state, as defined in s. 71.22 (1r), during the period beginning on January 1, 2010, and ending on December 31, 2012, for the small employer's first taxable year the assessment imposed on the small employer shall be 33 percent of the amount calculated for that employer under par. (a) and for the small employer's 2nd taxable year the assessment imposed on the small employer shall be 67 percent of the amount calculated for that employer under par. (a).

(4) COLLECTION AND CALCULATION OF ASSESSMENTS. (a) For taxable years beginning after December 31, 2009, the department shall impose on, and collect from, individuals the assessment amounts that the board calculates under sub. (2), either through an assessment that is collected as part of the income tax under subch. I of ch. 71, or through another method devised by the department. For taxable years beginning after December 31, 2009, the department shall impose on, and collect from, employers the assessment amounts that the board calculates under sub. (3), either through an assessment that is collected as part of the tax under subch. IV of ch. 71, or through another method devised by the department. Section 71.80 (1) (c), as it applies to ch. 71, applies to the department's imposition and collection of assessments under this section.

(b) The amounts that the department collects under par. (a) shall be deposited into the Healthy Wisconsin trust fund under s. 25.775.

(c) The board may annually increase or decrease the amounts that may be assessed under subs. (2) and (3). No annual increase under this paragraph may

exceed the percentage increase for medical inflation unless a greater increase is provided for by law.

(d) The maximum amount of assessment that the department may impose on, and collect from, a household under par. (a) is 4 percent of the annual limit on the contribution and benefit base of the Old–Age, Survivors, and Disability Insurance program, as calculated annually by the U.S. social security administration.

260.49 Advisory committee. (1) DUTIES. The board shall establish a health care advisory committee to advise the board on all of the following:

(a) Matters related to promoting healthier lifestyles.

(b) Promoting health care quality.

(c) Increasing the transparency of health care cost and quality information.

(d) Preventive care.

(e) Early identification of health disorders.

(f) Disease management.

(g) The appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms.

(h) Confidentiality of medical information.

(i) The appropriate use of technology.

(j) Benefit design.

(k) The availability of physicians, hospitals, and other providers.

(L) Reducing health care costs.

(m) Any other subject assigned to it by the board.

(n) Any other subject determined appropriate by the committee.

(2) MEMBERSHIP. The board shall appoint as members of the committee all of the following individuals:

(a) At least one member designated by the Wisconsin Medical Society, Inc.

(b) At least one member designated by the Wisconsin Academy of Family Physicians.

(c) At least one member designated by the Wisconsin Hospital Association, Inc.

(d) One member designated by the president of the Board of Regents of the University of Wisconsin System who is knowledgeable in the field of medicine and public health.

(e) One member designated by the president of the Medical College of Wisconsin.

(f) Two members designated by the Wisconsin Nurses Association, the Wisconsin Federation of Nurses and Health Professionals, and the Service Employees International Union.

(g) One member designated by the Wisconsin Dental Association.

(h) One member designated by statewide organizations interested in mental health issues.

(i) One member representing health care administrators.

(j) Other members representing health care professionals.

SECTION 77. 285.59 (1) (b) of the statutes is amended to read:

285.59 **(1)** (b) "State agency" means any office, department, agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law ~~which~~ that is entitled to expend moneys appropriated by law, including the legislature and the courts, the Wisconsin Housing and Economic Development Authority, the Bradley Center Sports and Entertainment Corporation, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin

Aerospace Authority, ~~and~~ the Wisconsin Health and Educational Facilities Authority, and the Healthy Wisconsin Authority.

SECTION 78. 609.01 (7) of the statutes is repealed.

SECTION 79. 609.10 of the statutes is repealed.

SECTION 80. 609.20 (1m) (c) of the statutes is repealed.

SECTION 81. 609.20 (1m) (d) of the statutes is repealed.

SECTION 82. 628.36 (4) (a) (intro.) of the statutes is amended to read:

628.36 **(4)** (a) (intro.) The commissioner shall provide information and assistance to ~~the department of employee trust funds,~~ employers and their employees, providers of health care services, and members of the public, as provided in par. (b), for the following purposes:

SECTION 83. 628.36 (4) (b) 1. of the statutes is repealed.

SECTION 84. 628.36 (4) (b) 2. of the statutes is repealed.

SECTION 85. 628.36 (4) (b) 3. of the statutes is repealed.

SECTION 86. 632.87 (5) of the statutes is amended to read:

632.87 **(5)** No insurer ~~or self–insured school district, city or village~~ may, under a policy, plan, or contract covering gynecological services or procedures, exclude or refuse to provide coverage for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the test or examination is performed by a licensed nurse practitioner, as defined in s. 632.895 (8) (a) 3., within the scope of the nurse practitioner's professional license, if the policy, plan, or contract includes coverage for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the test or examination is performed by a physician.

SECTION 87. 632.895 (8) (f) 4. of the statutes is created to read:

632.895 **(8)** (f) 4. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 88. 632.895 (9) (d) 4. of the statutes is created to read:

632.895 **(9)** (d) 4. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 89. 632.895 (10) (a) of the statutes is amended to read:

632.895 **(10)** (a) Except as provided in par. (b), every disability insurance policy ~~and every health care benefits plan provided on a self–insured basis by a county board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a political subdivision under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district under s. 120.13 (2)~~ shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and family services under s. 254.158.

SECTION 90. 632.895 (10) (b) 6. of the statutes is created to read:

632.895 **(10)** (b) 6. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 91. 632.895 (11) (a) (intro.) of the statutes is amended to read:

632.895 **(11)** (a) (intro.) Except as provided in par. (e), every disability insurance policy~~, and every self–insured health plan of the state or a county, city, village, town or school district,~~ that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

SECTION 92. 632.895 (11) (c) 1. of the statutes is amended to read:

632.895 **(11)** (c) 1. The coverage required under this subsection may be subject to any limitations, exclusions, or cost–sharing provisions that apply generally under the disability insurance policy ~~or self–insured health plan~~.

SECTION 93. 632.895 (11) (d) of the statutes is amended to read:

632.895 **(11)** (d) Notwithstanding par. (c) 1., an insurer ~~or a self–insured health plan of the state or a county, city, village, town or school district~~ may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

SECTION 94. 632.895 (11) (e) 3. of the statutes is created to read:

632.895 **(11)** (e) 3. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 95. 632.895 (12) (b) (intro.) of the statutes is amended to read:

632.895 **(12)** (b) (intro.) Except as provided in par. (d), every disability insurance policy~~, and every self–insured health plan of the state or a county, city, village, town or school district,~~ shall cover hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

SECTION 96. 632.895 (12) (c) of the statutes is amended to read:

632.895 **(12)** (c) The coverage required under this subsection may be subject to any limitations, exclusions, or cost–sharing provisions that apply generally under the disability insurance policy ~~or self–insured plan~~.

SECTION 97. 632.895 (13) (a) of the statutes is amended to read:

632.895 **(13)** (a) Every disability insurance policy~~, and every self–insured health plan of the state or a county, city, village, town or school district,~~ that provides

coverage of the surgical procedure known as a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

SECTION 98. 632.895 (13) (b) of the statutes is amended to read:

632.895 **(13)** (b) The coverage required under par. (a) may be subject to any limitations, exclusions, or cost–sharing provisions that apply generally under the disability insurance policy ~~or self–insured health plan~~.

SECTION 99. 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy~~,~~ ~~and every self–insured health plan of the state or a county, city, town, village or school district,~~ that provides coverage for a dependent of the insured shall provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

SECTION 100. 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy ~~or plan~~. This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

SECTION 101. 632.895 (14) (d) 7. of the statutes is created to read:

632.895 **(14)** (d) 7. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 102. Nonstatutory provisions.

(1) HEALTHY WISCONSIN PLAN.

(a) *Legislative findings.* In establishing the Healthy Wisconsin Plan under chapter 260 of the statutes, as created by this act, the legislature finds all of the following:

1. 'Costs.' Health care costs in Wisconsin are rising at an unsustainable rate making the need for comprehensive reform urgent. Rising costs are seriously threatening the ability of Wisconsin businesses to globally compete; farms to thrive; government to provide needed services; schools to educate; and local citizens to form new and successful business ventures. Some indicators of rising costs are the following:

a. Total health care spending in Wisconsin in 2007 is projected to be $42.3 billion, and is projected to grow 82 percent, to $76.9 billion, in the next decade.

b. The cost of employer–provided health care in Wisconsin increased by 9.3 percent in 2006, averaging $9,516 per employee. This figure is 26 percent more than the national average.

c. Employee premium contributions and out–of–pocket costs are rising faster than wages.

d. Rising costs have led to a decline in employer–provided health benefits. In 1979, 73 percent of private–sector Wisconsin workers had employer–based health insurance coverage; however, only 57 percent received health benefits in 2004.

e. At least one–half of all personal bankruptcies in the United States are the result of medical expenses. Over 75.7 percent of this group had insurance at the onset of illness. In 2004, there were 13,454 medical bankruptcies in Wisconsin affecting 37,360 people.

f. The costs of health services provided to individuals who are unable to pay are shifted to others. Of the $22 billion charged by hospitals in 2005, $736,000,000 was

not collected. Those who bear the burden of this cost shift have an increasingly difficult time paying their own health care costs.

2. 'Access.' There is a large and increasing number of people who have no health insurance or who are underinsured. For this growing population, health care is unaffordable and, most often, not received in the most timely and effective manner. Some indicators of lack of access to health care are as follows:

a. Over one 500,000 Wisconsin residents were uninsured at any given point during 2007.

b. Over 65 percent of the uninsured in Wisconsin are employed.

c. The uninsured are less likely to seek care and, thus, have poorer health outcomes compared to the insured population.

d. In 2007, total spending on the uninsured in Wisconsin is projected to reach over $1,000,000,000. About 23.2 percent of this amount will be in the form of uncompensated care; 21.7 percent will be provided through public programs; and 37.5 percent will be paid by the uninsured individuals.

3. 'Inequity.' The health care system contains inequities. Some indicators of inequity are as follows:

a. Wisconsin businesses are competing on an uneven playing field. The majority of Wisconsin businesses that do insure their workers are subsidizing those businesses that are not paying their fair share for health care.

b. Our current system forces the sick and the aging to pay far higher premiums than the healthy and those covered under group plans, rather than spreading the risk across the broadest pool possible.

c. The uninsured face medical charges by hospitals, doctors, and other health care providers that are 2.5 times what public and private health insurers pay.

4. 'Inefficiency.' Wisconsin does not have a clearly defined, integrated health care system. Our health care system is complex, fragmented, and disease–focused rather than health–focused, resulting in massive inefficiencies and placing inordinate administrative burdens on health care professionals. Some indicators of inefficiency are as follows:

a. Health care financing is accomplished through a patchwork of public programs, private sector employer–sponsored self–insurance, commercial insurance, and individual payers. The most recent study for Wisconsin estimates that about 27 cents of every health care dollar is spent on marketing, overhead, and administration, leaving only 73 cents left to deliver medical care.

b. This fragmentation and misaligned financial incentives lead, in some instances, to excessive or inadequate care and create barriers to coordination and accountability among health care professionals, payers, and patients.

c. The Institute of Medicine estimates that between 30 cents and 40 cents of every health care dollar is spent on costs of poor quality — overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency. Included in this inefficiency are an unacceptable number of adverse events attributable to medical errors. Patients receive appropriate care based on known "best practices" only about one–half of the time.

d. The best care results from the conscientious, explicit, and judicious use of current best evidence and knowledge of patient values by well–trained, experienced clinicians.

5. 'Limitations on reform.' Federal laws and programs, such as Medicaid, Medicare, Tri–Care, and Champus, constrain Wisconsin's ability to establish immediately a fully integrated health care system.

6. 'Wisconsin as a laboratory for the nation.' Wisconsin is in a unique position to successfully implement major health care reform. Many providers are already organized into comprehensive delivery systems and have launched innovative pilot programs to improve both the quality and efficiency of their care. Wisconsin is at the forefront in developing systems for health information transparency. Organizations such as the Wisconsin Collaborative for Healthcare Quality, Wisconsin Health Information Organization, and the Wisconsin Hospital Association have launched ambitious projects to provide data on quality, safety, and pricing.

(b) *Initial terms of Healthy Wisconsin Authority board.* Notwithstanding the lengths of terms of the members of the board of the Healthy Wisconsin Authority specified in section 260.05 (1) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

1. One member each from section 260.05 (1) (a), (b), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2010.

2. One member each from section 260.05 (1) (a), (b), and (e) of the statutes, as created by this act, for terms that expire on July 1, 2011.

3. One member each from section 260.05 (1) (c), (e), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2012.

4. One member each from section 260.05 (1) (d), (f), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2013.

5. One member each from section 260.05 (1) (a) and (b) of the statutes, as created by this act, for terms that expire on July 1, 2014.

6. One member each from section 260.05 (1) (a) and (b) of the statutes, as created by this act, for terms that expire on July 1, 2015.

(c) *Provisional appointments.* Notwithstanding the requirement for senate confirmation of the appointment of the members of the board of the Healthy Wisconsin Authority under section 260.05 (1) of the statutes, as created by this act, the initial members may be provisionally appointed by the governor, subject to confirmation by the senate. Any such appointment shall be in full force until acted upon by the senate, and when confirmed by the senate shall continue for the remainder of the term, or until a successor is chosen and qualifies. A provisional appointee may exercise all of the powers and duties of the office to which such person is appointed during the time in which the appointee qualifies. Any appointment made under this subsection that is withdrawn or rejected by the senate shall lapse. When a provisional appointment lapses, a vacancy occurs. Whenever a new legislature is organized, any appointments then pending before the senate shall be referred by the president to the appropriate standing committee of the newly organized senate.

(d) *Property tax credit.* If with respect to levies imposed for 2010, any taxing jurisdiction, as defined in section 74.01 (7) of the statutes, reduces the costs of providing health care coverage to its employees as a result of providing that coverage under the Healthy Wisconsin Plan under chapter 260 of the statutes, as created by this act, 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 2009, the taxing jurisdiction shall distribute at least 50 percent of the savings to the property taxpayers in the taxing jurisdiction as a reduction in the property tax assessments as of January 1, 2010. The reduction shall be calculated based on the equalized value of the property, as

determined under section 70.57 of the statutes, and shall reduce the property taxes otherwise payable in that year.

SECTION 103. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTHY WISCONSIN PLAN. The treatment of sections 13.94 (1) (dj) and (1s) (c) 5., 16.004 (7d) and (7h), 40.05 (4) (a) 4., (ag) (intro.), (ar), (b), and (be) and (4g) (d), 40.51 (1), (2), (7), (8), and (8m), 40.52 (1) (intro.), (1m), and (2), 40.98 (2) (a) 1., 49.45 (54), 49.473 (2) (c), 49.665 (5) (ag), 49.68 (3) (d) 1., 49.683 (3), 49.685 (6) (b), 49.687 (1m) (d), 59.52 (11) (c), 60.23 (25), 66.0137 (4), (4m) (b), and (5), 109.075 (9), 111.70 (1) (dm) and (4) (cm) 8s., 111.91 (2) (pt), 120.13 (2) (b) and (g), 149.12 (2) (em), 609.01 (7), 609.10, 609.20 (1m) (c) and (d), 628.36 (4) (a) (intro.) and (b) 1., 2., and 3., 632.87 (5), and 632.895 (8) (f) 4., (9) (d) 4., (10) (a) and (b) 6., (11) (a) (intro.), (c) 1., (d), and (e) 3., (12) (b) (intro.) and (c), (13) (a) and (b), and (14) (b), (c), and (d) 7. of the statutes, the renumbering and amendment of sections 40.51 (6) and 62.61 of the statutes, and the creation of sections 40.51 (6) (b) and 62.61 (1) (b) of the statutes take effect on January 1, 2010.

(END)