



Today

RMR

**SENATE AMENDMENT ,
TO SENATE SUBSTITUTE AMENDMENT 1,
TO 2007 SENATE BILL 40**

1 At the locations indicated, amend the substitute amendment as follows:
2 **1.** Page 5, line 6: before "or 279" insert "260."
3 **2.** Page 5, line 6: after that line insert:
4 "**SECTION 8h.** 13.48 (13) (a) of the statutes is amended to read:
5 13.48 (13) (a) Except as provided in par. (b) or (c), every building, structure or
6 facility that is constructed for the benefit of or use of the state, any state agency,
7 board, commission or department, the University of Wisconsin Hospitals and Clinics
8 Authority, the Fox River Navigational System Authority, the Healthy Wisconsin
9 Authority, or any local professional baseball park district created under subch. III
10 of ch. 229 if the construction is undertaken by the department of administration on
11 behalf of the district, shall be in compliance with all applicable state laws, rules,
12 codes and regulations but the construction is not subject to the ordinances or

1 regulations of the municipality in which the construction takes place except zoning,
2 including without limitation because of enumeration ordinances or regulations
3 relating to materials used, permits, supervision of construction or installation,
4 payment of permit fees, or other restrictions.”.

5 **3.** Page 7, line 20: before “or 279” insert “260.”

6 **4.** Page 15, line 8: after that line insert:

7 “**SECTION 17yd.** 13.94 (1) (dj) of the statutes is created to read:

8 13.94 (1) (dj) Annually, conduct a financial audit of the ^{Healthy} Wisconsin ~~Health Care~~

9 Plan under ch. 260 and file copies of each audit report under this paragraph with the
10 distributees specified in par. (b).

11 **SECTION 17yh.** 13.94 (1s) (c) 5. of the statutes is created to read:

12 13.94 (1s) (c) 5. The Healthy Wisconsin Authority for the cost of the audit under
13 sub. (1) (dj).”.

14 **5.** Page 16, line 19: after “Authority,” insert “the Healthy Wisconsin
15 Authority.”.

16 **6.** Page 25, line 6: before “and 279” insert “260.”

17 **7.** Page 25, line 11: before “and 279” insert “260.”

18 **8.** Page 25, line 17: before “and 279” insert “260.”

19 **9.** Page 25, line 19: after that line insert:

20 “**SECTION 71d.** 16.004 (7d) of the statutes is created to read:

21 16.004 (7d) CONTAINMENT OF HEALTH CARE COSTS. In consultation with the board
22 of the Healthy Wisconsin Authority, the secretary shall establish, by rule, a program
23 to contain health care costs in this state during any year in which the board

1 determines that health care costs increase at a rate exceeding the national average
2 of medical inflation, as defined in s. 260.01 (4).

3 **SECTION 71L.** 16.004 (7h) of the statutes is created to read:

4 16.004 (7h) EMPLOYER ASSESSMENTS TO THE HEALTHY WISCONSIN TRUST FUND. ✓

5 The secretary shall establish a methodology for allocating employer assessments
6 among state agencies to pay the Healthy Wisconsin trust fund for the operation and
7 funding of the ^{Healthy} Wisconsin ~~Health Care~~ Plan under ch. 260. State agencies shall pay,
8 from appropriations used to fund fringe benefit costs of state employees, to the
9 Healthy Wisconsin trust fund amounts determined by the secretary.”

10 **10.** Page 26, line 2: after “Remediation Authority,” insert “the Healthy
11 Wisconsin Authority.”

12 **11.** Page 26, line 22: before “or 279” insert “260.”

13 **12.** Page 29, line 18: before “or 279” insert “260.”

14 **13.** Page 29, line 18: after that line insert:

15 “**SECTION 80h.** 16.417 (1) (a) of the statutes is amended to read:

16 16.417 (1) (a) “Agency” means an office, department, independent agency,
17 institution of higher education, association, society, or other body in state
18 government created or authorized to be created by the constitution or any law, that
19 is entitled to expend moneys appropriated by law, including the legislature and the
20 courts, but not including an authority or the body created under subch. III of ch. 149
21 or under ch. 260.”

22 **14.** Page 30, line 11: before “or 279” insert “260.”

23 **15.** Page 34, line 9: before “or 279” insert “260.”

24 **16.** Page 34, line 19: before “or 279” insert “260.”

1 **17.** Page 35, line 18: before “or 279” insert “260”.

2 **18.** Page 38, line 5: before “or 279” insert “260”.

3 **19.** Page 42, line 1: after “Authority,” insert “the Healthy Wisconsin
4 Authority”.

5 **20.** Page 42, line 13: after “Authority,” insert “the Healthy Wisconsin
6 Authority”.

7 **21.** Page 43, line 7: after “Authority,” insert “the Healthy Wisconsin
8 Authority”.

9 **22.** Page 43, line 15: after “Authority,” insert “the Healthy Wisconsin
10 Authority”.

11 **23.** Page 43, line 22: after “Remediation Authority,” insert “the Healthy
12 Wisconsin Authority”.

13 **24.** Page 44, line 10: after “Authority,” insert “the Healthy Wisconsin
14 Authority”.

15 **25.** Page 44, line 18: after “Authority,” insert “the Healthy Wisconsin
16 Authority”.

17 **26.** Page 44, line 22: after “Authority,” insert “the Healthy Wisconsin
18 Authority”.

19 **27.** Page 45, line 6: after “Authority,” insert “the Healthy Wisconsin
20 Authority”.

21 **28.** Page 45, line 11: after “Remediation Authority,” insert “the Healthy
22 Wisconsin Authority”.

1 **29.** Page 45, line 16: after "Authority," insert "the Healthy Wisconsin
2 Authority."

3 **30.** Page 45, line 20: after "Remediation Authority," insert "the Healthy
4 Wisconsin Authority."

5 **31.** Page 48, line 7: before "or 279" insert "260."

6 **32.** Page 48, line 23: before "or 279" insert "260."

7 **33.** Page 274, line 1: before that line insert:

8

"(4m) ^{Healthy - (S)} WISCONSIN HEALTH CARE PLAN

9 (s) Healthy Wisconsin Authority SEG S -0- -0-".

10 **34.** Page 396, line 12: after that line insert:

11 "SECTION 573h. 20.855 (4m) of the statutes is created to read:

12

20.855 (4m) ^{Healthy - (S)} WISCONSIN HEALTH CARE PLAN. (s) *Healthy Wisconsin Authority.*

13 From the Healthy Wisconsin trust fund, a sum sufficient to pay the Healthy

14

Wisconsin Authority for the operation and funding of the ^{Healthy} Wisconsin Health Care

15 Plan under ch. 260."

16 **35.** Page 436, line 20: after that line insert:

17 "SECTION 678h. 25.17 (1) (ge) of the statutes is created to read:

18 25.17 (1) (ge) Healthy Wisconsin trust fund (s. 25.775)."

19 **36.** Page 440, line 14: after that line insert:

20 "SECTION 698h. 25.775 of the statutes is created to read:

21 **25.775 Healthy Wisconsin trust fund.** (1) There is established a separate,
22 nonlapsible trust fund designated as the Healthy Wisconsin trust fund, consisting
23 of all moneys appropriated or transferred to or deposited in the fund."

1 **37.** Page 485, line 17: after that line insert:

2 “**SECTION 765cb.** 40.05 (4) (a) 4. of the statutes is created to read:

3 40.05 (4) (a) 4. This paragraph does not apply to any insured employee or
4 retired insured employee who receives health care coverage under the ^{Healthy}Wisconsin
5 ~~Health Care~~ Plan under ch. 260.

6 **SECTION 765db.** 40.05 (4) (ag) (intro.) of the statutes is amended to read:

7 40.05 (4) (ag) (intro.) Beginning on January 1, 2004, except as otherwise
8 provided in accordance with a collective bargaining agreement under subch. I or V
9 of ch. 111 or s. 230.12 or 233.10, the employer shall pay for its currently employed
10 insured employees who are not covered under the ^{Healthy}Wisconsin ~~Health Care~~ Plan under
11 ch. 260:

12 **SECTION 765eb.** 40.05 (4) (ar) of the statutes is repealed.

13 **SECTION 765fb.** 40.05 (4) (b) of the statutes is amended to read:

14 40.05 (4) (b) Except as provided under pars. (bc) and (bp), accumulated unused
15 sick leave under ss. 13.121 (4), 36.30, 230.35 (2), 233.10, and 757.02 (5) and subch.
16 I or V of ch. 111 of any eligible employee shall, at the time of death, upon qualifying
17 for an immediate annuity or for a lump sum payment under s. 40.25 (1) or upon
18 termination of creditable service and qualifying as an eligible employee under s.
19 40.02 (25) (b) 6. or 10., be converted, at the employee’s highest basic pay rate he or
20 she received while employed by the state, to credits for payment of health insurance
21 premiums on behalf of the employee or the employee’s surviving insured dependents.
22 Any supplemental compensation that is paid to a state employee who is classified
23 under the state classified civil service as a teacher, teacher supervisor, or education
24 director for the employee’s completion of educational courses that have been

1 approved by the employee's employer is considered as part of the employee's basic
2 pay for purposes of this paragraph. The full premium for any eligible employee who
3 is insured at the time of retirement, or for the surviving insured dependents of an
4 eligible employee who is deceased, shall be deducted from the credits until the credits
5 are exhausted and paid from the account under s. 40.04 (10), and then deducted from
6 annuity payments, if the annuity is sufficient. The department shall provide for the
7 direct payment of premiums by the insured to the insurer if the premium to be
8 withheld exceeds the annuity payment. Upon conversion of an employee's unused
9 sick leave to credits under this paragraph or par. (bf), the employee or, if the employee
10 is deceased, the employee's surviving insured dependents may initiate deductions
11 from those credits or may elect to delay initiation of deductions from those credits,
12 but only if the employee or surviving insured dependents are covered by a
13 comparable health insurance plan or policy during the period beginning on the date
14 of the conversion and ending on the date on which the employee or surviving insured
15 dependents later elect to initiate deductions from those credits. If an employee or an
16 employee's surviving insured dependents elect to delay initiation of deductions from
17 those credits, an employee or the employee's surviving insured dependents may only
18 later elect to initiate deductions from those credits during the annual enrollment
19 period under par. (be). A health insurance plan or policy is considered comparable
20 if it provides hospital and medical benefits that are substantially equivalent to the
21 standard health insurance plan established under s. 40.52 (1) benefits provided
22 under the ^{Healthy} Wisconsin ~~Health~~ Plan under ch. 260.

23 **SECTION 765gb.** 40.05 (4) (be) of the statutes is amended to read:

24 40.05 (4) (be) The department shall establish an annual enrollment period
25 during which an employee or, if the employee is deceased, an employee's surviving

1 insured dependents may elect to initiate or delay continuation of deductions from the
 2 employee's sick leave credits under par. (b). An employee or surviving insured
 3 dependent may elect to continue or delay continuation of such deductions any
 4 number of times. If an employee or surviving insured dependent has initiated the
 5 deductions but later elects to delay continuation of the deductions, the employee or
 6 surviving insured dependent must be covered by a comparable health insurance plan
 7 or policy during the period beginning on the date on which the employee or surviving
 8 insured dependent delays continuation of the deductions and ending on the date on
 9 which the employee or surviving insured dependent later elects to continue the
 10 deductions. A health insurance plan or policy is considered comparable if it provides
 11 hospital and medical benefits that are substantially equivalent to ~~the standard~~
 12 ~~health insurance plan established under s. 40.52 (1) benefits provided under the~~
 13 Healthy Wisconsin Health Care Plan under ch. 260.

14 **SECTION 765hb.** 40.05 (4g) (d) of the statutes is created to read:

15 40.05 (4g) (d) This subsection shall not apply to an eligible employee who is
 16 receiving health care coverage under the Healthy Wisconsin Health Care Plan under ch. 260
 17 while on active duty in the U.S. armed forces.

18 **SECTION 765ib.** 40.51 (1) of the statutes is amended to read:

19 40.51 (1) The procedures and provisions pertaining to enrollment, premium
 20 transmitted and coverage of eligible employees for health care benefits shall be
 21 established by contract or rule except as otherwise specifically provided by this
 22 chapter. Notwithstanding subs. (6) and (7), an eligible employee who is covered
 23 under the Healthy Wisconsin Health Care Plan under ch. 260 may not receive coverage under
 24 this subchapter for any coverage provided the employee under ch. 260.

25 **SECTION 765jb.** 40.51 (2) of the statutes is amended to read:

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

17 **SECTION 765kb.** 40.51 (6) of the statutes is renumbered 40.51 (6) (a) and
18 amended to read:

19 40.51 (6) (a) This state shall offer to all of its eligible employees described in
20 subs. (10), (10m), and (16) at least 2 insured or uninsured health care coverage plans
21 providing substantially equivalent hospital and medical benefits, including a health
22 maintenance organization or a preferred provider plan, if those health care plans are
23 ~~determined by the group insurance board to be available in the area of the place of~~
24 ~~employment and are approved by the group insurance board.~~ The group insurance
25 board shall place each of the plans into one of 3 tiers established in accordance with

1 standards adopted by the group insurance board. The tiers shall be separated
2 according to the employee's share of premium costs.

3 **SECTION 765Lb.** 40.51 (6) (b) of the statutes is created to read:

4 40.51 (6) (b) The state may offer to its employees coverage for health care
5 benefits not provided to the employees under the ^{Healthy} Wisconsin ~~Health Care~~ Plan under
6 ch. 260.

7 **SECTION 765nb.** 40.51 (7) of the statutes is amended to read:

8 40.51 (7) Any employer, other than the state, may offer to all of its employees
9 ~~a health care coverage plan coverage for health care benefits not provided to the~~
10 ~~employees under the~~ ^{Healthy} Wisconsin ~~Health Care~~ Plan under ch. 260 through a program
11 offered by the group insurance board. Notwithstanding sub. (2) and ss. 40.05 (4) and
12 40.52 (1), the department may by rule establish different eligibility standards or
13 contribution requirements for such employees and employers and may by rule limit
14 the categories of employers, other than the state, which may be included as
15 participating employers under this subchapter.

16 **SECTION 765pb.** 40.51 (8) of the statutes is amended to read:

17 40.51 (8) Every health care coverage plan offered by the state under sub. (6)
18 (a) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to
19 (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3)
20 to (6), 632.895 (5m) and (8) to (14), and 632.896.

21 **SECTION 765qb.** 40.51 (8m) of the statutes is amended to read:

22 40.51 (8m) Every health care coverage plan offered by the group insurance
23 board under ~~sub.~~ subs. (6) (b) and (7) shall comply with ss. 631.89, 631.90, 631.93 (2),
24 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835,
25 632.85, 632.853, 632.855, and 632.895 (11) to (14) 632.87 (3) to (6).

1 **SECTION 765rb.** 40.52 (1) (intro.) of the statutes is amended to read:

2 40.52 (1) (intro.) The group insurance board shall establish by contract a
3 standard health insurance plan in which all insured employees shall participate
4 except as otherwise provided in this chapter. The Except as provided in sub. (1m),
5 the standard plan shall provide:

6 **SECTION 765sb.** 40.52 (1m) of the statutes is created to read:

7 40.52 (1m) The standard health insurance plan described under sub. (1) shall
8 not provide employees any health care coverage that the employees receive under the
9 ^{Healthy} Wisconsin ~~Health Care~~ Plan under ch. 260.

10 **SECTION 765tb.** 40.52 (2) of the statutes is amended to read:

11 40.52 (2) Health insurance benefits under this subchapter shall be integrated,
12 with exceptions determined appropriate by the group insurance board, with benefits
13 under federal plans for hospital and health care for the aged and disabled and with
14 benefits provided under the ^{Healthy} Wisconsin ~~Health Care~~ Plan under ch. 260. Exclusions
15 and limitations with respect to benefits and different rates may be established for
16 persons eligible under federal plans for hospital and health care for the aged and
17 disabled in recognition of the utilization by persons within the age limits eligible
18 under the federal program and for employees who receive benefits under the

19 ^{Healthy} Wisconsin ~~Health Care~~ Plan under ch. 260. The plan may include special provisions

20 for spouses and other dependents covered under a plan established under this
21 subchapter where one spouse is eligible under federal plans for hospital and health
22 care for the aged or under the ^{Healthy} Wisconsin ~~Health Care~~ Plan under ch. 260 but the

23 others are not eligible because of age or other reasons. As part of the integration, the
24 department may, out of premiums collected under s. 40.05 (4), pay premiums for the
25 federal health insurance.

1 **SECTION 765ub.** 40.98 (2) (a) 1. of the statutes is amended to read:

2 40.98 (2) (a) 1. The department shall design an actuarially sound health care
3 coverage program for employers that includes more than one group health care
4 coverage plan and that provides coverage beginning not later than January 1, 2001.
5 The health care coverage program shall be known as the "Private Employer Health
6 Care Purchasing Alliance". In designing the health care coverage program, the
7 department shall consult with the office of the commissioner of insurance and may
8 consult with the departments of commerce and health and family services. The
9 health care coverage program may not be implemented until it is approved by the
10 board. The health care coverage program shall not provide employees any health
11 care coverage that the employees receive under the ^{Health}Wisconsin ~~Health Care~~ Plan
12 under ch. 260."

13 **38.** Page 750, line 18: after that line insert:

14 **"SECTION 1608h.** 49.473 (2) (c) of the statutes is amended to read:

15 49.473 (2) (c) The woman is not covered under the ^{Health}Wisconsin ~~Health Care~~ Plan
16 under ch. 260 and is not eligible for any other health care coverage that qualifies as
17 creditable coverage in 42 USC 300gg (c), excluding the coverage specified in 42 USC
18 300gg (c) (1) (F)."

19 **39.** Page 762, line 18: after that line insert:

20 **"SECTION 1641r.** 49.665 (5) (ag) of the statutes is repealed."

21 **40.** Page 763, line 2: after that line insert:

22 **"SECTION 1645d.** 49.68 (3) (d) 1. of the statutes is amended to read:

23 49.68 (3) (d) 1. No aid may be granted under this subsection unless if the
24 recipient has ~~no other form of aid available from the federal medicare~~ Medicare

1 program, from private health, accident, sickness, medical, and or hospital insurance
 2 coverage, from the Wisconsin Health Care Plan under ch. 260, or from other health
 3 care coverage specified by rule under s. 49.687 (1m). If insufficient aid is available
 4 from other sources and if the recipient has paid an amount equal to the annual
 5 medicare Medicare deductible amount specified in subd. 2., the state shall pay the
 6 difference in cost to a qualified recipient. If at any time sufficient federal or private
 7 insurance aid or other health care coverage becomes available during the treatment
 8 period, state aid under this subsection shall be terminated or appropriately reduced.
 9 Any patient who is eligible for the federal medicare Medicare program shall register
 10 and pay the premium for medicare Medicare medical insurance coverage where
 11 permitted, and shall pay an amount equal to the annual medicare Medicare
 12 deductible amounts required under 42 USC 1395e and 1395L (b), prior to becoming
 13 eligible for state aid under this subsection.

} excluding the Healthy Wisconsin Plan under ch. 260 ✓

14 **SECTION 1645h.** 49.683 (3) of the statutes is amended to read:
 15 49.683 (3) ^{plain} ~~No~~ payment shall be made under this section for any portion of
 16 medical care costs that are payable under any state, federal, or other health care
 17 coverage program, including the Wisconsin Health Care Plan under ch. 260 or a
 18 health care coverage program specified by rule under s. 49.687 (1m), or under any
 19 grant, contract, or other contractual arrangement.

20 **SECTION 1645p.** 49.685 (6) (b) of the statutes is amended to read:
 21 49.685 (6) (b) Reimbursement shall not be made under this section for any
 22 blood products or supplies that are not purchased from or provided by a
 23 comprehensive hemophilia treatment center, or a source approved by the treatment
 24 center. Reimbursement shall not be made under this section for any portion of the
 25 costs of blood products or supplies that are payable under any other state, federal,

but excluding the Healthy Wisconsin
Plan under ch. 260. ✓

1 or other health care coverage program under which the person is covered, including
2 the Wisconsin Health Care Plan under ch. 260 or a health care coverage program
3 specified by rule under s. 49.687 (1m), or under any grant, contract, or other
4 contractual arrangement.

but excluding the Healthy Wisconsin Plan under ch. 260

5 **SECTION 1645t.** 49.686 (5) of the statutes is amended to read:

6 49.686 (5) REIMBURSEMENT LIMITATION. Reimbursement may not be made under
7 this section for any portion of the costs of AZT, the drug pentamidine or any drug
8 approved for reimbursement under sub. (4) (c) which are payable by an insurer, as
9 defined in s. 600.03 (27), or under the Wisconsin Health Care Plan under ch. 260."

10 **41.** Page 823, line 9: after that line insert:

11 **"SECTION 1846h.** 59.52 (11) (c) of the statutes is amended to read:

12 59.52 (11) (c) *Employee insurance.* Provide for individual or group hospital,
13 surgical and life insurance for county officers and employees and for payment of
14 premiums for county officers and employees. A county may elect to provide health
15 care benefits not provided under the ^{Healthy} Wisconsin Health Care Plan under ch. 260 to
16 its officers and employees and a county with at least 100 employees may elect to
17 provide health care benefits not provided under the ^{Healthy} Wisconsin Health Care Plan
18 under ch. 260 on a self-insured basis to its officers and employees. A county and one
19 or more cities, villages, towns, or other counties that together have at least 100
20 employees may jointly provide health care benefits not provided under the ^{Healthy} Wisconsin
21 Health Care Plan under ch. 260 to their officers and employees on a self-insured
22 basis. Counties that elect to provide health care benefits not provided under the
23 ^{Healthy} Wisconsin Health Care Plan under ch. 260 on a self-insured basis to their officers

Insert 14-9

1 and employees shall be subject to the requirements set forth under s. 120.13 (2) (c)
2 to (e) and (g).”.

3 **42.** Page 827, line 3: after that line insert:

4 “SECTION 1858h. 60.23 (25) of the statutes is amended to read:

5 60.23 (25) SELF-INSURED HEALTH PLANS. Provide health care benefits not
6 provided under the ^{Health}Wisconsin ~~Health Care~~ Plan under ch. 260 to its officers and
7 employees on a self-insured basis, subject to s. 66.0137 (4).”.

8 **43.** Page 832, line 12: after that line insert:

9 “SECTION 1873j. 62.61 of the statutes is renumbered 62.61 (1) (intro.) and
10 amended to read:

11 62.61 (1) (intro.) The common council of a 1st class city may, by ordinance or
12 resolution, provide do any of the following:

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

17 (c) Elect to offer to all of its employees a health care coverage plan through a
18 program offered by the group insurance board under ch. 40. Municipalities ~~which~~
19 that elect to participate under s. 40.51 (7) are subject to the applicable sections of ch.
20 40 instead of this section.

21 (2) Contracts for insurance under this section may be entered into for active
22 officers and employees separately from contracts for retired officers and employees.
23 Appropriations may be made for the purpose of financing insurance under this
24 section. Moneys accruing to a fund to finance insurance under this section, by

1 investment or otherwise, may not be diverted for any other purpose than those for
2 which the fund was set up or to defray management expenses of the fund or to
3 partially pay premiums to reduce costs to the city or to persons covered by the
4 insurance, or both.

5 **SECTION 1873k.** 62.61 (1) (b) of the statutes is created to read:

6 62.61 (1) (b) Subject to s. 260.37, provide for, including the payment of
7 premiums of, group health insurance for active city officers and city employees and
8 their respective dependents.”.

9 **44.** Page 832, line 17: after that line insert:

10 **SECTION 1874h.** 66.0137 (4) of the statutes is amended to read:

11 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
12 a village provides health care benefits not provided under the ^{Healthy}Wisconsin Health Care
13 Plan under ch. 260 under its home rule power, or if a town provides health care
14 benefits ^{Healthy}not provided under the Wisconsin Health Care Plan under ch. 260, to its
15 officers and employees on a self-insured basis, the self-insured plan shall comply
16 with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747
17 (3), 632.85, 632.853, 632.855, 632.87 (4), ~~(5), and (6), 632.895 (9) to (14),~~ 632.896, and
18 767.513 (4).

19 **SECTION 1874n.** 66.0137 (4m) (b) of the statutes is amended to read:

20 66.0137 (4m) (b) A political subdivision and one or more other political
21 subdivisions, that together have at least 100 employees, may jointly provide health
22 care benefits not provided under the ^{Healthy}Wisconsin Health Care Plan under ch. 260 to
23 their officers and employees on a self-insured self-insured basis.

24 **SECTION 1874t.** 66.0137 (5) of the statutes is amended to read:

1 66.0137 (5) HOSPITAL, ACCIDENT, AND LIFE INSURANCE. ~~The Subject to s. 260.37,~~
2 the state or a local governmental unit may provide for the payment of premiums for
3 hospital, ~~surgical and other~~ health and accident insurance and life insurance for
4 employees and officers and their spouses and dependent children. A local
5 governmental unit may also provide for the payment of premiums for hospital and
6 surgical care for its retired employees. In addition, a local governmental unit may,
7 by ordinance or resolution, elect to offer to all of its employees a health care coverage
8 plan through a program offered by the group insurance board under ch. 40. A local
9 governmental unit that elects to participate under s. 40.51 (7) is subject to the
10 applicable sections of ch. 40 instead of this subsection.”.

11 **45.** Page 844, line 14: after that line insert:

12 “**SECTION 1934c.** 70.11 (41p) of the statutes is created to read:

13 70.11 (41p) HEALTHY WISCONSIN AUTHORITY. ✓ All property owned by the Healthy
14 Wisconsin Authority, provided that use of the property is primarily related to the
15 purposes of the authority.”.

16 **46.** Page 923, line 2: after that line insert:

17 “**SECTION 2021p.** 71.26 (1) (be) of the statutes is amended to read:

18 71.26 (1) (be) *Certain authorities.* Income of the University of Wisconsin
19 Hospitals and Clinics Authority, of the Health Insurance Risk-Sharing Plan
20 Authority, ~~and of the Healthy Wisconsin Authority,~~ of the Fox River Navigational
21 System Authority, and of the Wisconsin Aerospace Authority.”.

22 **47.** Page 1128, line 25: after that line insert:

23 “**SECTION 2356d.** 77.54 (9a) (a) of the statutes is amended to read:

1 77.54 (9a) (a) This state or any agency thereof, the University of Wisconsin
2 Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Health
3 Insurance Risk-Sharing Plan Authority, the Healthy Wisconsin Authority, ✓ and the
4 Fox River Navigational System Authority.”

5 **48.** Page 1210, line 10: after that line insert:

6 “**SECTION 2606p.** 100.45 (1) (dm) of the statutes is amended to read:

7 100.45 (1) (dm) “State agency” means any office, department, agency,
8 institution of higher education, association, society or other body in state
9 government created or authorized to be created by the constitution or any law which
10 is entitled to expend moneys appropriated by law, including the legislature and the
11 courts, the Wisconsin Housing and Economic Development Authority, the Bradley
12 Center Sports and Entertainment Corporation, the University of Wisconsin
13 Hospitals and Clinics Authority, the Wisconsin Health and Educational Facilities
14 Authority, the Wisconsin Aerospace Authority, and the Fox River Navigational
15 System Authority, and the Healthy Wisconsin Authority.” ✓

16 **49.** Page 1223, line 12: after that line insert:

17 “**SECTION 2651p.** 109.075 (9) of the statutes is created to read:

18 109.075 (9) This section does not apply to an employer that ceases providing
19 health care benefits to its employees because the employees are covered under the
20 Healthy Wisconsin Health Care Plan under ch. 260.”

21 **50.** Page 1228, line 9: after that line insert:

22 “**SECTION 2664d.** 111.70 (1) (dm) of the statutes is amended to read:

23 111.70 (1) (dm) “Economic issue” means salaries, overtime pay, sick leave,
24 payments in lieu of sick leave usage, vacations, clothing allowances in excess of the

1 actual cost of clothing, length-of-service credit, continuing education credit, shift
2 premium pay, longevity pay, extra duty pay, performance bonuses, health insurance
3 coverage of benefits not provided under the ~~Wisconsin Health Care~~ ^{Healthy ← Healthy} Plan under ch.
4 260, life insurance, dental insurance, disability insurance, vision insurance,
5 long-term care insurance, worker's compensation and unemployment insurance,
6 social security benefits, vacation pay, holiday pay, lead worker pay, temporary
7 assignment pay, retirement contributions, supplemental retirement benefits,
8 severance or other separation pay, hazardous duty pay, certification or license
9 payment, limitations on layoffs that create a new or increased financial liability on
10 the employer and contracting or subcontracting of work that would otherwise be
11 performed by municipal employees in the collective bargaining unit with which there
12 is a labor dispute.”

13 **51.** Page 1228, line 17: after that line insert:

14 “SECTION 2677. 111.70 (4) (cm) 8s. of the statutes is amended to read:

15 111.70 (4) (cm) 8s. ‘Forms for determining costs.’ The commission shall
16 prescribe forms for calculating the total increased cost to the municipal employer of
17 compensation and fringe benefits provided to school district professional employees.
18 The cost shall be determined based upon the total cost of compensation and fringe
19 benefits provided to school district professional employees who are represented by
20 a labor organization on the 90th day before expiration of any previous collective
21 bargaining agreement between the parties, or who were so represented if the
22 effective date is retroactive, or the 90th day prior to commencement of negotiations
23 if there is no previous collective bargaining agreement between the parties, without
24 regard to any change in the number, rank or qualifications of the school district

1 professional employees. For purposes of such determinations, any cost increase that
2 is incurred on any day other than the beginning of the 12-month period commencing
3 with the effective date of the agreement or any succeeding 12-month period
4 commencing on the anniversary of that effective date shall be calculated as if the cost
5 increase were incurred as of the beginning of the 12-month period beginning on the
6 effective date or anniversary of the effective date in which the cost increase is
7 incurred. For the purpose of determining if a municipal employer has maintained
8 current fringe benefits under sub. (1) (nc) 1. a., the commission shall consider the
9 municipal employer to have maintained its health care coverage benefit if the
10 municipal employer provides health care coverage to its school district professional
11 employees through the ^{Healthy} Wisconsin ~~Health~~ Care Plan under ch. 260. In each collective
12 bargaining unit to which subd. 5s. applies, the municipal employer shall transmit
13 to the commission and the labor organization a completed form for calculating the
14 total increased cost to the municipal employer of compensation and fringe benefits
15 provided to the school district professional employees covered by the agreement as
16 soon as possible after the effective date of the agreement.

17 **SECTION 2680j.** 111.91 (2) (pt) of the statutes is created to read:

18 111.91 (2) (pt) Health care coverage of employees under the ^{Healthy} Wisconsin ~~Health~~
19 ~~Care~~ Plan under ch. 260.”

20 **52.** Page 1241, line 22: after that line insert:

21 **SECTION 2737d.** 120.13 (2) (b) of the statutes is amended to read:

22 120.13 (2) (b) Provide health care benefits not provided under the ^{Healthy} Wisconsin
23 Health Care Plan under ch. 260 on a self-insured basis to the employees of the school
24 district if the school district has at least 100 employees. In addition, any 2 or more

Healthy ✓

1 school districts which together have at least 100 employees may jointly provide
2 health care benefits not provided under the Wisconsin Health Care Plan under ch.
3 260 on a self-insured basis to employees of the school districts.

4 **SECTION 2737h.** 120.13 (2) (g) of the statutes is amended to read:

5 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
6 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
7 632.85, 632.853, 632.855, 632.87 (4), ~~(5), and (6), 632.895 (9) to (14), 632.896, and~~
8 767.513 (4).”.

9 **53.** Page 1260, line 13: after that line insert:

10 “**SECTION 2879h.** 149.12 (2) (em) of the statutes is created to read:

11 149.12 (2) (em) No person who is eligible for coverage under the Wisconsin
12 Health Care Plan under ch. 260 is eligible for coverage under the plan under this
13 chapter.”

Healthy

14 **54.** Page 1310, line 4: before “or 279” insert “260.”.

15 **55.** Page 1327, line 2: after that line insert:

16 “**SECTION 3069b.** Chapter 260 of the statutes is created to read:

17 CAPS HEALTHY **CHAPTER 260**
18 **WISCONSIN HEALTH CARE PLAN**

19 **260.01 Definitions.** In this chapter:

- 20 (1) “Authority” means the Healthy Wisconsin Authority.
- 21 (2) “Board” means the board of ~~directors~~ trustees of the authority.
- 22 (3) “Health care network” means a provider-driven, coordinated group of

23 health care providers comprised of primary care physicians, medical specialists,
24 physician assistants, nurses, clinics, one or more hospitals, and other health care

except as otherwise provided

1 providers and facilities, including providers and facilities that specialize in mental
2 health services and alcohol or other drug abuse treatment.

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

7 (5) "Plan" means the ^{Healthy} Wisconsin ~~Health Care~~ Plan.

8 **260.05 Creation and organization of authority.** (1) CREATION AND
9 MEMBERSHIP OF BOARD. There is created a public body corporate and politic to be
10 known as the "Healthy Wisconsin Authority." The ^{NONVOTING} members of the board shall consist
11 of the secretary of employee trust funds and 4 representatives from the advisory
12 committee under s. 260.49 who are health care personnel and administrators,
13 selected by the advisory committee. ~~The secretary of employee trust funds and the~~
14 ~~representatives from the advisory committee shall be nonvoting members.~~ The
15 secretary of employee trust funds shall serve as the initial chairperson of the board
16 until such time as the board elects a chairperson from its voting membership. The
17 board shall ^{also} consist of the following voting members, nominated by the governor and
18 with the advice and consent of the senate appointed, for staggered 6-year terms:

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

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

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

Subsect 22-7

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

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

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

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

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

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

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

22 **(3) BOARD MEMBER RESPONSIBILITY AS TRUSTEE.** Each member of the board shall
23 be responsible for taking care that the highest level of independence and judgment
24 is exercised at all times in administering the plan and overseeing the individuals and
25 organizations selected to implement the plan.

1 (4) DUTIES. The board shall:

2 (a) Establish and administer a health care system in this state that ensures
3 that all eligible persons have access to high quality, timely, and affordable health
4 care. In establishing and administering the health care system, except as otherwise
5 provided by law, the board shall seek to attain all of the following goals:

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

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

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

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

13 (c) Appoint an executive director, who shall serve at the pleasure of the board.

14 The board may delegate to one or more of its members or its executive director any
15 powers and duties the board considers proper. The executive director shall receive
16 such compensation as may be determined by the board.

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

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

23 (f) Establish an independent and binding appeals process for resolving
24 disputes over eligibility and other determinations made by the board.

any other determination is entitled to judicial review of the determination. ✓
Any person who is adversely affected by a board eligibility or other determination is entitled to judicial review of the determination. ✓

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

3 (h) Contract for annual, independent, program evaluations and financial
4 audits that measure the extent to which the plan is achieving the goals under par.

5 (a) 1. to 3. The board may not enter into a contract with the same auditor for more
6 than 6 years.

7 (i) Accept bids from health care networks in accordance with the criteria set out
8 in s. 260.30, or make payments to fee-for-service providers in accordance with s.
9 260.30. The board shall consult with the department of employee trust funds in
10 determining the most effective and efficient way of purchasing health care benefits.

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

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

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

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

19 (c) Maintain an office.

20 (d) Sue and be sued.

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

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

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

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

5 (i) Procure liability insurance.

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

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

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

12 (m) Issue bonds, operating notes, or other obligations.

13 **260.10 Eligibility. (1) COVERED PERSONS.** Except as provided in subs. (2) to
14 (5) and subject to sub. (6), a person is eligible to participate in the plan if the person
15 satisfies all of the following criteria:

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

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

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

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

1 (e) Unless a waiver requested under sub. (6) (b) has been granted and is in
2 effect, the person is not eligible for Medical Assistance under subch. IV of ch. 49 or
3 for health care coverage under the Badger Care health care program under s. 49.665.

4 (2) GAINFULLY EMPLOYED. If a person and the members of the person's
5 immediate family do not meet the criteria under sub. (1) (a) and (b), but do meet the
6 criteria under sub. (1) (c) to (e) and the person is gainfully employed in this state, as
7 defined by the board, the person and the members of the person's immediate family
8 are eligible to participate in the plan.

9 (3) DEPENDENT CHILDREN. If a child under age 18 resides with his or her parent
10 in this state but the parent does not yet meet the residency requirement under sub.
11 (1) (a), the child is eligible to participate in the plan regardless of the length of time
12 the child has resided in this state.

13 (4) PREGNANT WOMEN. A pregnant woman who resides in this state who does
14 not yet meet the residency requirement under sub. (1) (a) is eligible to participate in
15 the plan regardless of the length of time the pregnant woman has resided in this
16 state.

17 (5) COLLECTIVE BARGAINING AGREEMENT. A person who is eligible to participate
18 in the plan under sub. (1), (2), (3), or (4) and who receives health care coverage under
19 a collective bargaining agreement that is in effect on January 1, 2009, is not eligible
20 to participate in the plan until the day on which the collective bargaining agreement
21 expires or the day on which the collective bargaining agreement is extended,
22 modified, or renewed.

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

1 (b) 1. The department shall develop a request for a waiver from the secretary
 2 of the federal department of health and human services to provide coverage under
 3 the plan to individuals who are eligible for Medical Assistance under subch. IV of ch.
 4 49 in the low-income families category, as determined by the department, ~~or~~ for
 5 health care coverage under the Badger Care health care program under s. 49.665.
 6 The waiver request shall be written so as to allow the use of federal financial
 7 participation to fund, to the maximum extent possible, health care coverage under
 8 the plan for the individuals specified in this subdivision.

9 2. The department shall, not later than July 1, 2008, submit the waiver request
 10 developed under subd. 1. to a special legislative committee that shall be comprised
 11 of the members of the joint committee on finance and the members of the standing
 12 committees of the senate and the assembly with subject matter jurisdiction over
 13 health issues. The special legislative committee shall have 60 days to review and
 14 comment to the department on the waiver request.

15 (c) ~~The~~ department may develop waiver requests to the appropriate federal
 16 agencies to permit funds from federal health care services programs to be used for
 17 health care coverage for persons under the plan.

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

20 (a) Place of permanent abode.

21 (b) Substantial presence this state. In defining "substantial presence in this
 22 state," the board shall consider such factors as the amount of time per year that an
 23 individual is actually present in the state and the amount of taxes that an individual
 24 pays in this state, except that, if the individual attends school outside of this state
 25 and is under 23 years of age, the factors shall include the amount of time that the

1 and to individuals who are eligible

Except as required under par. (b),

1 individual's parent or guardian is actually present in the state and the amount of
2 taxes that the individual's parent or guardian pays in this state, and if the individual
3 is in active service with the U.S. armed forces outside of this state, the factors shall
4 include the amount of time that the individual's parent, guardian, or spouse is
5 actually present in the state and the amount of taxes that the individual's parent,
6 guardian, or spouse pays in this state.

7 (c) Immediate family.

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

10 **260.12 Office of outreach, enrollment, and advocacy. (1) ESTABLISHMENT.**
11 The board shall establish an office of outreach, enrollment, and advocacy. The office
12 shall contract with nonprofit organizations to perform the outreach, enrollment, and
13 advocacy functions specified in this section, and to review the health care payment
14 and services records of persons who are participating, or who are eligible to
15 participate, in the plan and who have provided the office with informed consent for
16 the review. The office may not contract with any organization under this subsection
17 that provides services under the plan or that has any other conflict of interest, as
18 described in sub. (3).

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

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

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

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

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

8 (e) Act as an advocate for plan participants having questions, difficulties, or
9 complaints about their health care services or coverage, including investigating and
10 attempting to resolve the complaint. Investigation should include, when
11 appropriate, consulting with the health care advisory committee under s. 260.49
12 regarding best practice guidelines.

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

17 (g) Provide information to the public, agencies, legislators, and others
18 regarding problems and concerns of plan participants and, in consultation with the
19 health care advisory committee under s. 260.49, make recommendations for
20 resolving those problems and concerns.

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

23 **(3) CONFLICT OF INTEREST LIMITATION.** The office and its employees and
24 contractors shall not have any conflict of interest relating to the performance of their
25 duties. There is a conflict of interest if, with respect to the office's director, employees,

1 or contractors, or a person affiliated with the office's director, employees, or
2 contractors, any of the following exists:

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

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

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

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

12 **260.15 Benefits.** (1) **GENERALLY.** The board shall establish a health care plan
13 that will take effect on January 1, 2009. The plan shall provide the same benefits
14 as those that were in effect as of January 1, 2007, under the state employee health
15 plan under s. 40.51 (6). The board may adjust the plan benefits to provide additional
16 cost-effective treatment options if there is evidence-based research that the options
17 are likely to reduce health care costs, avoid health risks, or result in better health
18 outcomes.

19 (2) **ADDITIONAL BENEFITS.** In addition to the benefit requirements under sub.
20 (1), the plan shall provide coverage for mental health services and alcohol or other
21 drug abuse treatment to the same extent as the plan covers treatment for physical
22 conditions. *→ and coverage for preventive dental care for children up to 18 years of age*

23 **260.20 Cost sharing.** (1) **NO COST SHARING.** The plan shall cover the following
24 preventive services without any cost-sharing requirement:

25 (a) Prenatal care for pregnant women.

1 (b) Well-baby care.

2 (c) Medically appropriate examinations and immunizations for children up to
3 18 years of age.

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

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

8 (f) Medically appropriate colonoscopies.

9 (g) Preventive dental care. ✓ → for children up to 18[✓] years
of age

10 (h) Other preventive services or procedures, as determined by the board, for
11 which there is scientific evidence that exemption from cost sharing is likely to reduce
12 health care costs or avoid health risks.

13 (i) Chronic care services, provided that the participant receiving the services
14 is participating in, and complying with, a chronic disease management program as
15 defined by the board.

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

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

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

1 4. Except for copayments and coinsurance, the plan shall provide a participant
2 with full coverage for all covered services and articles after the participant has
3 received covered services and articles totaling the applicable deductible amount
4 under this paragraph, regardless of whether the participant has paid the deductible
5 amount.

6 (b) *Provider requirements.* 1. A provider that provides to a participant a
7 covered service or article to which a deductible applies shall charge the participant
8 for the service or article the payment rate established by the board under s. 260.30
9 (7) (b) 1. *→ Insat 33-9 ✓*

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

14 3. A provider may not charge any interest, penalty, or late fee on any deductible
15 amount owed by a participant unless the deductible amount owed is at least 6
16 months past due and the provider has provided the participant with notice of the
17 interest, penalty, or late fee at least 90 days before the interest, penalty, or late fee
18 payment is due. Interest may not exceed 1 percent per month, and any penalty or
19 late fee may not exceed the provider's reasonable cost of administering the unpaid
20 bill.

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

24 Copayments and coinsurance.
25 (3) ~~COINSURANCE AND COPAYMENTS~~ (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

1 copayment of \$20 for medical, hospital, and related health care services, as
2 determined by the board.

regardless of age, *primary*

3 (b) *Specialist provider services without referral.* A participant who receives
4 health care services from a specialist provider without a referral from his or her care
5 *provider* ~~coordinator~~ under the plan shall be required to pay 25 percent of the cost of the
6 services provided.

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

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

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

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

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

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

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

23 (a) Subject to par. (b), a participant who is 18 years of age or older on January
24 1 of a year may not be required to pay more than \$2,000 during that year in total cost
25 sharing under subs. (2) and (3).

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

3 **260.30 Service areas; selection and payment of health care providers**
4 **and health care networks. (1) ESTABLISHMENT OF AREAS WHERE SERVICES WILL BE**
5 **PROVIDED.** The board may establish areas in the state, which may be counties,
6 multicounty regions, or other areas, for the purpose of receiving bids from health care
7 networks. These areas shall be established so as to maximize the level and quality
8 of competition among health care networks or to increase the number of provider
9 choices available to eligible persons and participants in the areas.

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

13 (a) An option, known as the "fee-for-service option," under which participants
14 must choose a primary care provider, may be referred by the primary care provider
15 to any medical specialist, and may be admitted by the primary care provider or
16 specialist to any hospital or other facility, for the purpose of receiving the benefits
17 provided under this chapter. Under this option, the board, with the assistance of one
18 or more administrators chosen by a competitive bidding process and with whom the
19 board has contracted, shall pay directly, at the provider payment rates established
20 by the board under sub. (7) (b) 1., for all health care services and articles that are
21 covered under the plan.

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

1 designated by the board to the extent that qualifying health care networks exist in
2 the area.

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

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

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

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

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

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

22 (c) Ensures all of the following:

23 1. That participants living in an area that a health care network serves shall
24 not be required to drive more than 30 minutes, or, in a metropolitan area served by

1 mass transit, spend more than 60 minutes using mass transit facilities, in order to
2 reach the offices of at least 2 primary care providers, as defined by the board.

3 2. That physicians, physician assistants, nurses, clinics, hospitals, and other
4 health care providers and facilities, including providers and facilities that specialize
5 in mental health services and alcohol or other drug abuse treatment, are
6 conveniently available, as defined by the board, to participants living in every part
7 of the area that the health care network serves.

8 (d) Ensures that participants have access, 24 hours a day, 7 days a week, to a
9 toll-free hotline and help desk that is staffed by persons who live in the area and who
10 have been fully trained to communicate the benefits provided under this chapter and
11 the choices of providers that participants have in using the health care network.

12 (e) Ensures that each participant who chooses the health care network selects
13 a primary care ~~physician~~ who is responsible for overseeing all of the participant's
14 care. *provider* ✓

15 (f) Will provide each participant with medically appropriate and high-quality
16 health care, including mental health services and alcohol or other drug abuse
17 treatment, in a highly coordinated manner.

18 (g) Emphasizes, in its policies and operations, the promotion of healthy
19 lifestyles; preventive care, including early identification of and response to high-risk
20 individuals and groups, early identification of and response to health disorders,
21 disease management, including chronic care management, and best practices,
22 including the appropriate use of primary care, medical specialists, medications, and
23 hospital emergency rooms; and the utilization of continuous quality improvement
24 standards and practices that are generally accepted in the medical field.

1 (h) Has developed and is implementing a program, including providing
2 incentives to providers when appropriate, to promote health care quality, increase
3 the transparency of health care cost and quality information, ensure the
4 confidentiality of medical information, and advance the appropriate use of
5 technology.

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

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

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

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

24 (m) Agrees to enroll and provide the benefits specified in this chapter to all
25 participants who choose the network, regardless of the participant's age, sex, race,

1 religion, national origin, sexual orientation, health status, marital status, disability
2 status, or employment status, except that a health care network may do one of the
3 following:

4 1. Limit the number of new enrollees it accepts if the health care network
5 certifies to the board that accepting more than a specified number of enrollees would
6 make it impossible to provide all enrollees with the benefits specified in this chapter
7 at the level of quality that the network is committed to maintaining, provided that
8 the health care network uses a random method for deciding which new enrollees it
9 accepts.

10 2. Limit the participants that it serves to a specific affinity group, such as
11 farmers or teachers, that the health care network has certified to the board, provided
12 that the limitation does not involve discrimination based on any of the factors
13 described in this paragraph and has neither been created for the purpose, nor will
14 have the effect, of screening out higher-risk enrollees. This subdivision applies only
15 to affinity groups that are in existence as of December 31, 2007.

16 **(5) CERTIFICATION OF HEALTH CARE NETWORKS AND CLASSIFICATION OF BIDS.** (a) The
17 board shall review the bids submitted under sub. (3), the information submitted by
18 bidders pertaining to whether the bidders are qualifying health care networks, and
19 other evidence provided to the board as to whether a particular bidder is a qualifying
20 health care network.

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

24 (c) With respect to all health care networks that the board certifies under par.
25 (b), the board shall open the submitted, sealed bids at a predetermined time. The

1 board shall classify the certified health care networks according to price and quality
2 measures after comparing their risk-adjusted per-month bids and assessing their
3 quality. The board shall classify the network that bid the lowest price as the
4 lowest-cost network, and shall classify as a low-cost network any network that has
5 bid a price that is close to the price bid by the lowest-cost network. Any other
6 network shall be classified as a higher-cost network.

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

19 (7) PAYMENTS TO NETWORKS AND PROVIDERS. (a) *Payments to health care*
20 *networks.* 1. On behalf of each participant who selects or has been assigned to a
21 certified health care network that has been classified under sub. (5) (c) as the
22 lowest-cost network or a low-cost network and as performing well on quality
23 measures, the board shall pay monthly to the health care network the full
24 risk-adjusted per-member per-month amount that was bid by the network. The
25 dollar amount shall be actuarially adjusted for the participant based on age, sex, and

the fee for service option or

or to the fee for service option if that is the lowest cost option

1 other appropriate risk factors determined by the board. A participant who selects
2 or is assigned to the lowest-cost network or a low-cost network shall not be required
3 to pay any additional amount to the network.

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

14 3. The board may retain a percentage of the dollar amounts established for each
15 participant under subds. 1. and 2. to pay to certified health care networks that have
16 incurred disproportionate risk not fully compensated for by the actuarial adjustment
17 in the amount established for each eligible person. Any payment to a certified health
18 care network under this subdivision shall reflect the disproportionate risk incurred
19 by the health care network.

20 (b) *Payments to fee-for-service providers.* 1. The board shall establish provider
21 payment rates that will be paid to providers of covered services and articles that are
22 provided to participants who choose the fee-for-service option under sub. (2) (a) and
23 for purposes of payments for covered services and articles to which a deductible
24 applies. The payment rates shall be fair and adequate to ensure that this state is able
25 to retain the highest quality of medical practitioners. The board shall limit increases

1 in the provider payment rate for each service or article such that any increase in per
2 person spending under the plan does not exceed the national rate of medical
3 inflation.

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

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

14 4. If the board has determined under sub. (5) (c) that there is at least one
15 certified low-cost health care network in an area, which may be the lowest-cost
16 health care network, and if the fee-for-service option offered in that area has not
17 been classified as a low-cost choice under subd. 3., the cost to a participant enrolling
18 in the fee-for-service option shall be determined as follows:

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

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

8 c. If there is available to the participant only one certified health care network
9 classified under sub. (5) (c) as a low-cost network, or as the lowest-cost network, the
10 person shall pay the difference between the cost of the lowest-cost health care
11 network and the risk-adjusted cost established under subd. 3. for the fee-for-service
12 option, except that the amount paid may not exceed \$25 per month for an individual,
13 and \$50 per month for a family, as adjusted for medical inflation.

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

17 **(8) INCENTIVE PAYMENTS TO FEE-FOR-SERVICE PROVIDERS.** Health care providers
18 and facilities providing services under the fee-for-service option under sub. (2) (a)
19 shall be encouraged to collaborate with each other through financial incentives
20 established by the board. Providers shall work with facilities to pool infrastructure
21 and resources; to implement the use of best practices and quality measures; and to
22 establish organized processes that will result in high-quality, low-cost medical care.
23 The board shall establish an incentive payment system to providers and facilities
24 that comply with this subsection, in accordance with criteria established by the
25 board.

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

13 **260.35 Subrogation.** The board and authority are entitled to the right of
 14 subrogation for reimbursement to the extent that a participant may recover
 15 reimbursement for health care services and items in an action or claim against any
 16 3rd party.

17 **260.37 Employer-provided health care benefits.** Nothing in this chapter
 18 prevents an employer, or a Taft-Hartley trust on behalf of an employer, from paying
 19 all or part of any cost sharing under s. 260.20 or 260.30, or from providing any health
 20 care benefits not provided under the plan, for any of the employer's employees.

21 **260.40 Assessments, individuals and businesses. (1) DEFINITIONS.** In this
 22 section:

- (a) "Department" means the department of revenue.
- (b) "Eligible individual" means an individual who is eligible to participate in
 the plan, other than an employee or a self-employed individual.

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1 ~~(c)~~ (c) "Employee" means an individual who has an employer.

2 ~~(e)~~ (d) "Employer" means a person who is required under the Internal Revenue

3 Code to file form 941. →

4 ~~(h)~~ (e) "Self-employed individual" means an individual who is required under the
5 Internal Revenue Code to file schedule SE.

6 ~~(i)~~ (f) "Social security wages" means:

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

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

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

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

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

subject to the following: ~~(4)~~

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

INS 45-22 ✓

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

(3) EMPLOYERS. Subject to 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.

(4) COLLECTION AND CALCULATION OF ASSESSMENTS. (a) For taxable years beginning after December 31, 2008, 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, 2008, 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.

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

- 1 (a) Matters related to promoting healthier lifestyles.
- 2 (b) Promoting health care quality.
- 3 (c) Increasing the transparency of health care cost and quality information.
- 4 (d) Preventive care.
- 5 (e) Early identification of health disorders.
- 6 (f) Disease management.
- 7 (g) The appropriate use of primary care, medical specialists, prescription
- 8 drugs, and hospital emergency rooms.
- 9 (h) Confidentiality of medical information.
- 10 (i) The appropriate use of technology.
- 11 (j) Benefit design.
- 12 (k) The availability of physicians, hospitals, and other providers.
- 13 (L) Reducing health care costs.
- 14 (m) Any other subject assigned to it by the board.
- 15 (n) Any other subject determined appropriate by the committee.

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

- 18 (a) At least one member designated by the Wisconsin Medical Society, Inc.
- 19 (b) At least one member designated by the Wisconsin Academy of Family
20 Physicians.
- 21 (c) At least one member designated by the Wisconsin Hospital Association, Inc.
- 22 (d) One member designated by the president of the Board of Regents of the
23 University of Wisconsin System who is knowledgeable in the field of medicine and
24 public health.

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

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

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

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

9 (i) One member representing health care administrators.

10 (j) Other members representing health care professionals.”.

11 **56.** Page 1353, line 13: after that line insert:

12 “SECTION 3085c. 285.59 (1) (b) of the statutes is amended to read:

13 285.59 (1) (b) “State agency” means any office, department, agency, institution
14 of higher education, association, society, or other body in state government created
15 or authorized to be created by the constitution or any law ~~which~~ that is entitled to
16 expend moneys appropriated by law, including the legislature and the courts, the
17 Wisconsin Housing and Economic Development Authority, the Bradley Center
18 Sports and Entertainment Corporation, the University of Wisconsin Hospitals and
19 Clinics Authority, the Fox River Navigational System Authority, the Wisconsin
20 Aerospace Authority, and the Wisconsin Health and Educational Facilities
21 Authority, and the Healthy Wisconsin Authority.”.

22 **57.** Page 1497, line 21: after that line insert:

23 “SECTION 3660d. 609.01 (7) of the statutes is repealed.

24 SECTION 3660h. 609.10 of the statutes is repealed.