2005 DRAFTING REQUEST

Bill

Received: **10/06/2005**

Received By: **pkahler**

Wanted: **Soon**

Identical to LRB:

For: **Ann Nischke (608) 266-8580**

By/Representing: **DOA, Nancy Wenzel**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters: **jkreye**

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Nischke@legis.state.wi.us**

Carbon copy (CC:) to: **nwenzel@tds.net**
joseph.kreye@legis.state.wi.us

Pre Topic:

No specific pre topic given

Topic:

Create authority to administer HIRSP, changes to HIRSP, Health Care Tax Credit plan

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Instructions:

See Attached

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By/Representing: **DOA, Nancy Wenzel**

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Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**
Health - miscellaneous

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Gielow@legis.state.wi.us**

Carbon copy (CC:) to: **joseph.kreye@legis.state.wi.us**

Pre Topic:

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Topic:

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/?	pkahler	/p1 wlj 10/12	10/12 P8	10/12 P8			

FE Sent For:

<END>

Kahler, Pam

From: Johnston, James 6-3420
Sent: Wednesday, September 28, 2005 4:14 PM
To: Kahler, Pam
Cc: Jablonsky, Sue
Subject: HIRSP Authority

Pam,
The chart below highlights the status we are attempting to create for the new HIRSP board. The goal is to provide the board with greater latitude to independently set day-to-day operation of the program, but within statutory parameters relating to certain policyholder issues. I would like to know if an authority is the best structure to accomplish these goals. If the desired flexibly can be obtained without authority status, and if the primarily hallmark of an authority is the ability to independently take on debt; it may be that another structure may be preferable.

Thanks,
Jim

Organization	Public board entity, similar to WHEDA.
Purpose	Function as insurer of last resort in the individual market to protect vulnerable population and serve as state's alternative coverage plan under HIPAA.
Open Meetings	Require compliance with state open meetings laws.
OCI Oversight	• Commissioner of Insurance is chair of the Board. • Governor appoints the Board members. • Benefit design changes would subject to Commissioner approval. Current insurance laws and regulatory codes would be retained, creating a regulatory environment similar to other insurers.
Public Accountability	• There are public representatives on the Board. • General benefit design, eligibility, subsidy determination and funding structure would be outlined in statute. • Board would be subject to legislative audits and other existing state ethics, open records and procurement and purchasing requirements. • Current insurance laws and regulatory codes would be retained, creating a regulatory environment similar to other insurers.
Government Entity	The board would be a quasi-governmental entity.

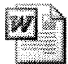
Kahler, Pam

From: Johnston, James
Sent: Monday, October 03, 2005 2:43 PM
To: Kahler, Pam
Cc: Jablonsky, Sue
Subject: HIRSP

Attachments: HIRSP Summary 9-30.doc

Pam,
In preparing for our meeting this Wednesday, I've attached a summary of most of the major components for the HIRSP bill draft. We can walk through each point in detail when we meet, but if you have questions before then please call. Our goal is to get this passed during the fall floor period, with a 1/1/06 effective date.

Thanks,
Jim



HIRSP Summary 9-30.doc (35 KB)...

HIRSP PLAN

Summary of decisions for redesigned the HIRSP program.

- Create a new chapter in the authority statutes (chapter 235+) for the HIRSP program. Existing insurance law (e.g., audits exams, etc.) would apply.

- Create a public authority to administer the plan which would be run by a board consisting of 13 members, including representatives of industry groups, and two public members, all of whom would be identified in statute similar to the current draft. The Governor would appoint the board chair and members. The board would be subject to other laws pertaining to public organizations, such as: open meeting laws, state procurement procedures, required to report annually to the Governor and the Legislature and would be subject to an annual audit by the Legislative Audit Bureau.

- Require that the NAIC model benefit language be included in statute, including any state mandated coverage, subject to OCI approval. Delete language pertaining to exclusions, copays, deductibles and premiums (other than that the board must set these amounts and that the premiums cannot exceed 200% of the standard rate). Specify that the board may develop other plans that are responsive to market conditions.

- Retain the funding of cost sharing with premiums at 60% policyholder, 20% insurers and 20% provider contribution. Maintain current law funding for the premium and deductible subsidies at 50% insurers and 50% providers and specify that these subsidies are for people with incomes below $25,000 by retaining language in s. 149.165. Specify that any federal funds received would be applied to offset the cost of the subsidies for insurers and providers.

- Change the residency requirement to three months and the number of denials from insurers to two. These changes would not apply to HIPAA eligible policyholders. Retain language giving persons with AIDS automatic eligibility. Retain Joint Finance language that HIRSP is the coverage of last resort (e.g., can't be eligible for FamilyCare, CIP, COP, etc.) Retain Finance language that enrollment in Medicare Part D is required for Plan 2 policyholders beginning Jan. 1, 2006.

- Retain the current payment rate structure of an enhanced MA rate and continue to require providers to be MA certified. Require providers to contribute 20% toward plan costs.

- Require the board to apply for status as a state pharmacy assistance program under Medicare Part D and include Part D coverage in definition of Medicare. Changes effective January 1, 2006...

2100 WEQ

- Create a $5 million tax credit for insurers who support HIRSP starting in tax year 2006 and first payable in FY08. The language would allow a carry-forward credit.
Further discussions are needed with DOR regarding the ability to delay payment of the credit.

- Retain the existing contract with the plan administrator.

- Create a new HCTC plan administered by the HIRSP authority. This plan would be exclusively for HCTC policyholders and would not be subsidized by insurers or providers. (health care tax credit)

same pool / plan?
AB 351

10-5

meeting w/ Jim Johnston (DOA) & Nancy Wenzel (Wis assn of Health Care Plans)

(1) gov appoint (for now)

13 voting + Commissioner as nonvoting

chair? who appoint or elect?

(2) fund language? yes, as in draft

(3) NAIC benefits A. (1) (p 283) and "HIRSP benefit language"

but keep (k) + (p) + (q) in current law

(want to keep "benefit levels" in proposed language

these are the minimum benefits (not exclusive)

(4) "200%" was amdt to PS (Senate)

(5) fed funding received by State for high risk pool used for subsidies

(then was a provider disc?)

If fed $ left over, used for program costs after subsidies

→ need fed appropriation (all moneys received)

LRB
Wisconsin Legislative Reference Bureau

eligible for subsidies: [not elig individual HCTC]

↓

non-medicare persons
& Medicare persons for premiums
but not deductibles

keep all of 149.165

(6) elig → same as PS (but dept of rev changes)

(7) for HCTC → ~~separate~~ plan
bd comes up w/ comparable benefits
design plan by a certain date?

use fed language that is comparable

(8) executive director or chief executive officer?
Ck all authorities

ALTERNATIVE ONE

A. The plan shall offer health care coverage consistent with ~~major medical expense~~ comprehensive coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the plan, its schedule of benefits, exclusions and other limitations shall be established by the board and subject to the approval of the Commissioner.

ALTERNATIVE TWO

A. (1) Outline of Benefits. Covered expenses shall be ~~the usual, customary and reasonable charge in the locality for~~ the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services, ~~subject to provisions of Subsection B:~~

(a) Hospital services;

(b) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;

(c) Drugs requiring a physician's prescription;

(d) Skilled nursing services of a licensed skilled nursing facility for not more than 120 days during a policy year;

(e) Services of a home health agency up to a maximum of 270 services per year;

(f) Use of radium or other radioactive materials;

(g) Oxygen;

(h) Anesthetics;

(i) Prostheses other than dental;

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which is prescribed;

(k) Diagnostic X-rays and laboratory tests;

(l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(m) Services of a physical therapist;

(n) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;

(o) Outpatient services for diagnosis and treatment of mental and nervous disorders provided that a covered person shall be required to make a fifty percent (50%) copayment, and that the plan's payment shall not exceed $[insert number].

(2) Exclusions. Covered expenses shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(b) Care which is primarily for custodial or domiciliary purposes;

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is medically necessary;

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(f) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;

(g) Dental care except as provided in Subsection A(1)(l);

(h) Eyeglasses and hearing aids;

(i) Illness or injury due to acts of war;

(j) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to an eligible person each policy year;

(k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service;

(l) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of additional premiums;

(m) Any expense or charge for services, drugs or supplies that are not provided in accord with generally accepted standards of current medical practice;

(n) Any expense or charge for routine physical examinations or tests;

(o) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;

(p) Any expense incurred for benefits provided under the laws of the United States and this state, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;

(q) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;

(r) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;

(s) Any expense or charge for sterilization or sterilization reversals;

(t) Any expense or charge for weight loss programs, exercise equipment or treatment of obesity, except when certified by a physician as morbid obesity (at least two (2) times normal body weight);

(u) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;

(v) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant; or

(w) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community.

B. In establishing the plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through ~~a representative number of large employers in the state~~.

C. The board may adjust any deductibles and coinsurance factors annually according to the Medical Component of the Consumer Price Index.

D. Preexisting Conditions.

(1) Plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such conditions during the six-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

Drafting Note: In order to reduce the premiums and costs of the plan, states may wish to provide for a longer exclusion period for preexisting conditions; as noted above, however, no preexisting condition exclusion may be applied to a federally defined eligible individual. States will need to weigh the need to provide access to individuals with preexisting conditions with the increased costs associated with a shorter preexisting condition exclusion period.

(2) Subject to Paragraph (1), ~~Such~~ the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that

(a) Application for pool coverage is made not later than ~~sixty (60)~~ sixty-three (63) days following such involuntary termination and, in such case, coverage in the plan shall be effective from the date on which such prior coverage was terminated; and

(b) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

E. Nonduplication of Benefits.

(1) The plan shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this paragraph.

Section 9. Collective Action

NASCHIP/CA State Risk Pool Benefit Survey

Wisconsin

State: **Wisconsin**
Name: **Health Insurance Risk Sharing Plan (HIRSP)**
Version: **Plan 1 – major medical**
Plan 2 – Medicare supplement*
Deductible: **$1,000/$2,500, $500 PL2**

Co-insurance: **80/20 of next $5,000, then 100%**
Lifetime Max: **$1,000,000**
Pre-ex Condition Waiting Period: **6 months, 0 months HIPAA-eligible**

Benefits/Features Brief description	Covered?
Out of Pocket Maximum Depends upon plan.	YES
Outpatient Care/Doctor Visits Subject to deductible and co-insurance/medical necessity. Routine visits not covered.	YES
Inpatient Care/Hospital Subject to deductible and co-insurance/medical necessity.	YES
Surgery Subject to deductible and co-insurance/medical necessity.	YES
Prescription Drug Coverage Medically necessary prescription drugs and insulin, subject to a 20 % drug coinsurance up to a maximum of $25/RX.	YES
Maternity and Newborn Subject to deductible and co-insurance/medical necessity.	YES
Ambulance Subject to deductible and co-insurance/medical necessity.	YES
Diagnostic/X-Ray and Laboratory Tests Subject to deductible and co-insurance/medical necessity.	YES
Skilled Nursing Care 30 days of confinement, upon the specific recommendation and under the supervision of a physician.	YES
Home Health Visits Physician certification required, 40 visits/year, RN care, RN-supervised home health aide, OT, ST, PT.	YES
Hospice Care Subject to deductible and co-insurance/medical necessity.	YES
Transplant Coverage Subject to deductible and co-insurance/medical necessity; experimental guidelines.	YES
Rehabilitation Inpatient Subject to deductible and co-insurance/medical necessity.	YES
Rehabilitation Outpatient Subject to deductible and co-insurance/medical necessity.	YES
Durable Medical Equipment Subject to deductible and co-insurance/medical necessity.	YES
Mental Health & Chemical Dependency Outpatient – $3,000/year maximum; inpatient – AODA 30 days/year; inpatient Mental Health 60 days/year.	YES
Physical Therapy Subject to deductible and co-insurance/medical necessity.	YES
Speech Therapy Subject to deductible and co-insurance/medical necessity.	YES

Benefits/Features Brief description	Covered?
Occupational Therapy Subject to deductible and co-insurance/medical necessity.	YES
Preventive Care Limited to mammograms, papanicolau tests, PSA and pelvic exams.	YES
Dental Care Limited to oral surgery covered for unerupted, impacted teeth, or with respect to mouth tissues when not performed in connection with tooth extraction or repair.	YES
Vision Care Limited to initial pair of glasses or contact lenses following cataract surgery, and for specific medical conditions.	NO

Other Significant Services (list)

Service	Covered?
Chiropractic services subject to deductible and co-insurance/medical necessity.	
AIDS	YES
Transplants	YES
Specific Diseases Kidney disease $30,000 annual maximum benefit per calendar year.	YES
Waiting Periods other than Pre-ex	NA

*Plan 2 Medicare Supplement is identical to Plan 1, but pays secondary to Medicare.

Medicaid Benefits Categories

Acute Care

Mandatory Items and Services

- Physicians' services
- Laboratory and x-ray services
- In patient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment services for individuals under 21
- Family planning services and supplies
- Federally-qualified health center services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services

Optional Items and Services

- Medical care or remedial care furnished by licensed practitioners under state law
- Prescribed drugs
- Diagnostic, screening, preventive, and rehabilitative services
- Clinic services
- Primary care case management services
- Dental Services, Dentures
- Physical therapy and related services
- Prosthetic devices, Eyeglasses
- TB-related services
- Other specified medical and remedial care

Long-term care

Institutional Services

Mandatory Items and Services

- Nursing facility services for individuals 21 or over

Optional Items and Services

- Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental disease
- Intermediate care facility for individuals with mental retardation services
- Inpatient psychiatric hospital services for individuals under age 21

Home & Community-Based Services

Mandatory Items and Services

- Home health care services (for individuals entitled to nursing facility care)

Optional Items and Services

- Home health care services for individuals not entitled to nursing facility care
- Case management services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Private duty nursing services
- Hospice care
- Services furnished under a PACE (Programs of All-inclusive Care for the Elderly) program
- Home- and community-based services (under waiver, subject to budget neutrality requirements)

(c) Each hospital and ambulatory surgical center shall collect the service charges assessed under this section. In the event that no payment is made by or on behalf of the patient for services rendered, the fee assessed under this section shall be waived. Each hospital and ambulatory surgical center shall remit to the plan for each reporting period, as established in the plan of operation, but no more frequently than [insert time period], charges collected during that reporting period in accordance with the reporting and remittance procedures established by the board. Failure to pay within sixty (60) days after the end of the reporting period shall cause the hospital or ambulatory surgical center to be liable to the plan for an amount determined by the board, not to exceed $500, plus interest. Any hospital or ambulatory surgical center found to have failed to pay according to this section on three (3) or more occasions during a six-month period shall be liable for an amount determined by the board, no less than $500 and not to exceed $1,500 per failure, together with attorney fees, interest and court costs.

(d) For the purposes of this subsection, "private pay patient" means a person whose admission to a hospital or ambulatory surgical center is not reimbursed through health or other insurance or any other health benefit plan or arrangement.

ALTERNATIVE FOUR. Appropriation of General Revenue

The deficit incurred by the plan shall be funded through amounts appropriated by the state legislature [and from other sources of revenue as provided in this section]. The board shall operate the plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds appropriated by the state legislature [and from other sources of additional revenue as provided in this section]. After determining the amount of funds appropriated to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

Drafting Note: States may wish to consider using other sources of dedicated revenues to support state plans, including tobacco and alcohol taxes, per-person payroll taxes, income tax surcharges, or revenues from state lotteries.

Section 8. Benefits

Drafting Note: Two alternatives for Subsection A are offered for establishing covered services for the plan. Alternative One provides for the plan board to establish the covered services and exclusions, subject to the approval of the Commissioner. The advantages of this alternative are that legislators can leave the benefit determinations to experts in plan design and that benefits can be easily modified from time to time to recognize changes in marketplace standards and medical technology.

Alternative Two contains a list of covered services and exclusions for states that wish to include the benefits and exclusions in the statute. The advantage of Alternative Two is that the list contains the benefits and exclusions found in some high risk plans in operation at the time the model was adopted. The list is intended to be inclusive and states may wish to add or delete benefits or exclusions to reflect the state's policy preferences. The list is an outline of the benefits and exclusions; it is not policy language.

Consideration should be given prior to enactment to the cost effectiveness of inclusion or deletion of benefit mandates or other minimum benefit standards. Consideration also should be given to providing sufficient flexibility in the plan to allow for the delivery of services through health maintenance organizations, preferred provider organizations and other managed care arrangements.

Drafting Note: HIPAA requires that federally defined eligible individuals have a choice of coverage available to them. This requirement is satisfied by the plan offering at least two different deductible options to such individuals.

HIRSP Benefit Language

In addition to listing the outline of benefits from the NAIC Model Act, we need to also include the following language.

In establishing the plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with comprehensive health insurance coverage offered in the individual market in the state.

Memo

To: Jim Johnston, Sue Jablonsky, and Nancy Wenzel

From: Pam Kahler

Subject: Authority cross–references

The sections in this list include cross–references to one or more, most, or all of the current authorities. Some of the sections may not be appropriate for the HIRSP authority (on the assumption that the HIRSP authority will not issue bonds, make grants or loans, or guarantee loans, I haven't included the ones that I'm *sure* are inappropriate); some of the sections may be appropriate but you may not want them to apply to the HIRSP authority. In some cases, a similar section must be drafted.

Please review the following list to determine if you want to include (note that some "inclusions" are actually "exclusions") a cross–reference to, or a similar provision for, the HIRSP authority:

1. s. 7.33 (1) (c)
2. s. 13.172 (1)
3. s. 13.48 (10) (b) 3m., (12) (b) 4., and (13) (a)
4. s. 13.62 (2)
5. s. 13.94 (1) (b) and (g) and (4) (a) 1.
6. s. 13.95
7. s. 16.002 (2)
8. s. 16.004 (4), (5), and (12) (a)
9. s. 16.008 (2)
10. s. 16.01 (1)
11. s. 16.045 (1) (a)
12. s. 16.41 (4)
13. s. 16.417 (1) (b)
14. s. 16.52 (7)
15. s. 16.528 (1) (a)

16. s. 16.53 (2)
17. s. 16.54 (9) (a) 1.
18. s. 16.611 (2) (a) and (c)
19. s. 16.70 (2)
20. s. 16.75 (1m)
21. s. 16.765 (1), (2), (4), (5), (6), (7) (intro.) and (d), and (8)
22. s. 16.838 (1) (b)
23. s. 16.845 (1)
24. s. 16.85 (2) and (16)
25. s. 16.865 (8)
26. s. 19.42 (5), (10) (h), (m), (n), and (o), and (13) (g), (L), (m), and (n)
27. s. 20.9275 (1) (g)
28. s. 23.175 (1) (b)
29. s. 25.50 (1) (d)
30. s. 40.02 (54)
31. s. 70.11 (41)
32. s. 71.26 (1) (be)
33. s. 77.54 (9) (a)
34. s. 100.45 (1) (dm)
35. s. 101.177 (1) (d)
36. s. 103.49 (1) (f)
37. s. 230.03 (3)
38. s. 281.75 (4) (b) 3.
39. s. 285.59 (1) (b)
40. s. 704.31 (3)

1. The authority is included in s. 1.12 (1) (b) since it is a "body in state government which is created... by law for which an appropriation is made." OK?

2. I assume you do not want something similar to 13.094 for the authority to be reviewed by joint finance.

3. Is s. 13.48 (10) (b) 3m. consistent with your intent?

4. Do you want to exempt the authority from s. 13.48 (12)?

5. Do you want to include the authority in s. 13.48 (13) (a)?

6. Do you want the authority included in s. 13.95 (intro.)?

7. Do you want the authority included in the definition under s. 16.01 (1)?

8. As drafted, the authority is subject to s. 16.15. OK? 560.9810

9. The authority is not included in the definition under s. 16.375. OK?

10. As drafted, the authority is not subject to s. 16.417. OK?

11. As drafted, s. 16.61 does not apply to the authority. OK?

12. Do you want the authority to be subject to s. 16.611, or 16.62?

13. By including the authority in the definition under s. 16.70 (2), the authority is not subject to the purchasing provisions that apply to "agencies" under ss. 16.70 to 16.78.

However, the authority is subject to the provisions under ss. 16.72 (2) (e) and (f) and 16.75 (1m), (8) (a) 1. and 2., and (9). OK?

14. Do you want the authority to be covered by s. 16.845?

15. Do you want something similar to s. 16.85 (14) for the authority?

16. Do you want to do anything in s. 16.851 since the navigational system is a "state–owned or state–leased facility"?

17. Look at s. 16.865 (2) and (8). I have excluded the authority from the definition of "agency" under sub. (8) but you may want to change it in light of the language in sub. (2).

18. By cross–reference the authority is included in the definition under s. 16.966 (1). OK?

19. As drafted, the authority is not subject to subch. VII of ch. 16. OK?

20. Do you want the authority excluded from the definition under s. 19.32 (1)? It is included under current law.

21. The chief executive officer and the members of the board of the authority are included in the definition of "official required to file" under s. 19.42 (10). OK?

22. The authority is included in the definition under s. 19.62 (8). OK?

23. The authority is included in the definition under s. 19.82 (1). OK?

24. I have not included the authority in the definition under s. 25.50 (1) (d) since the authority is setting up its own investment corporation. OK?

25. Do you want the authority treated as a "state agency" in s. 29.604. Under current law, it is not considered a state agency.

26. The authority is not subject to ch. 35. OK?

27. I have exempted the authority from the payment of property taxes, corporate income taxes, and sale and use taxes. OK? Also, if you want the authority to have to pay for municipal services, s. 70.119 will have to be amended.

28. The authority is included in the definition under s. 101.055 (2) (a). OK?

29. The authority is included in the definition of "employer" under s. 103.10. OK? Also, the personnel commission will be investigating the authority under s. 103.10 (12). OK?

30. The authority is included in the definition under s. 103.15 (1) (a). OK?

31. As drafted, the authority is subject to s. 103.49. OK?

32. As drafted, the authority is subject to ch. 104. OK?

33. The authority is included in the definition under s. ~~137.04 (3)~~ 137.11(9)(a). OK?

34. The reference to "authority" in ss. 88.172 (2) (a), 181.0670 (3) (a) 1. and (b), 181.0855 (2) (a), 185.367 (2) (a) and (3), and 186.096 (2) (b) and (3) includes the Fox Authority. OK?

35. The authority is subject to subch. III of ch. 230. See s. 230.80 (4) OK?

36. The authority is subject to ch. 287. See ss. 287.01 (5m) and 287.22 (2) (b) and (2m). OK?

37. The authority is included in the definition of "state authority" in ss. 341.17 (9) (a) 4., 343.235 (1) (d), and 343.24 (4) (a) 4. OK?

38. Do you want language similar to s. 704.31 (3)?

39. Do you want to exclude the authority from the definition under s. 895.65 (1) (c)?

560-9810