HEALTH AND HUMAN SERVICES

CHILDREN

Under current law, a court assigned to exercise jurisdiction under the Children's Code and the Juvenile Justice Code (juvenile court) is required to include in a dispositional order placing a child outside the home, an extension of a dispositional order continuing the placement of a child outside the home, and a consent decree maintaining a child in a placement outside the home findings that continued placement of the child in the home would be contrary to the welfare of the child, that reasonable efforts have been made to prevent the removal of the child from the home, and that reasonable efforts have been made to achieve the goal of the child's permanency plan, which is a plan designed to ensure that the child is reunified with his or her family whenever appropriate or that the child quickly attains a placement providing long-term stability. This bill requires the juvenile court to make the finding that reasonable efforts have been made to achieve the goal of the child's permanency plan in a termination of parental rights (TPR) order if a permanency plan has previously been filed with respect to the child.

Under current law, in an action affecting the family, for example, a divorce proceeding, if the circuit court finds that neither parent is able to care for the child adequately or is fit and proper to have care and custody of the child, the circuit court

may declare the child to be in need of protection or services and transfer legal custody of the child to a relative of the child, to the county department of human services or social services (county department), or to a licensed child welfare agency. This bill also permits a circuit court to transfer legal custody of a child found to be in need of protection or services in an action affecting the family in Milwaukee County to DHFS. In addition, if the circuit court transfers legal custody of a child found to be in need of protection or services in an action affecting the family to a county department, DHFS, or a licensed child welfare agency, the bill requires the circuit court to refer the matter to the juvenile court intake worker, who is required to conduct an intake inquiry to determine whether a petition alleging the child to be in need of protection or services should be filed with the juvenile court. Further, the bill requires a circuit court to include in an order transferring legal custody of a child found to be in need of protection or services in an action affecting the family a finding that placement of the child in his or her home would be contrary to the welfare of the child and, subject to certain exceptions, a finding that reasonable efforts have been made to prevent the removal of the child from the home.

The bill also requires a juvenile court, when ordering a child to be placed outside the home under the supervision of a county department or, in Milwaukee County,

DHFS to order the child into the placement and care responsibility of the county department or DHFS and to assign the county department or DHFS primary responsibility for providing services to the child. In addition, the bill requires a county department, DHFS, or DOC, when placing a child outside the home under a voluntary agreement, to specifically state in the voluntary agreement that the county department, DHFS, or DOC has placement and care responsibility for the child and has primary responsibility for providing services to the child.

Under current law, if a child who has been taken into custody under the Children's Code or the Juvenile Justice Code is not released, the juvenile court is required to hold a hearing to determine whether the child should continue to be held in custody and is required to include in an order to hold a child in temporary physical custody certain findings, including a finding that reasonable efforts have been made to prevent the removal of the child from the home. Currently, if for good cause shown sufficient information is not available for the juvenile court to make that finding, the county department, DHFS in Milwaukee County, or the agency primarily responsible for providing services to the child is required to file with the juvenile court sufficient information for the juvenile court to make that finding within five days after the date of the temporary physical custody order. This bill requires that

information to be filed with the juvenile court within five days, excluding Saturdays, Sundays, and legal holidays, after the date on which the temporary physical custody order is granted.

***** ANALYSIS FROM -1220/5 *****

HEALTH AND HUMAN SERVICES

CHILDREN

Under current law, DHFS may license a person to operate a day care center, a county department of human services or social services (county department) may certify a day care provider for reimbursement under the Wisconsin Works (W-2) program, and a school board may establish or contract for the provision of day care programs for children. This bill requires DWD to provide a child care quality rating system that rates the quality of the child care provided by a child care provider licensed by DHFS that receives reimbursement under the W-2 program for the child care provided or that volunteers for rating under the system. DWD must make the rating information provided under the system available to parents, guardians, and legal custodians of children who are recipients, or prospective recipients, of care and supervision from a child care provider that is rated under the system, including making that information available on DWD's Internet site.

***** ANALYSIS FROM -0259/1 *****

HEALTH AND HUMAN SERVICES

CHILDREN

Current law specifies age-related basic maintenance rates that are paid to a foster parent for the care and maintenance of a child. Currently, those rates are $317 for a child under five years of age, $346 for a child 5 to 11 years of age, $394 for a child 12 to 14 years of age, and $411 for a child 15 years of age or over. This bill increases those rates, beginning on January 1, 2008, to $333 for a child under five years of age, $363 for a child 5 to 11 years of age, $414 for a child 12 to 14 years of age, and $432 for a child 15 years of age or over, and beginning on January 1, 2009, to $349 for a child under five years of age, $381 for a child 5 to 11 years of age, $433 for a child 12 to 14 years of age, and $452 for a child 15 years of age or over.

*** ANALYSIS FROM -1221/6 ***
HEALTH AND HUMAN SERVICES

CHILDREN

Under current law, DHFS contracts for activities to augment the amount of moneys received under Title IV-E of the federal Social Security Act for foster care and adoption assistance, under Title XVIII of that act for Medicare, and under Title XIX of that act for Medical Assistance (MA) (income augmentation services receipts) and receives moneys under Title XIX of that act in reimbursement of the cost of providing targeted case management services to children whose care is not eligible

for reimbursement under Title IV-E of that act (MA targeted case management moneys). Current law requires DHFS to use income augmentation services receipts to support costs that are exclusively related to the operational costs of income augmentation activities and to distribute not less than 50 percent of income augmentation services receipts received for MA to counties for social, mental health, developmental disabilities, and alcohol and other drug abuse services. In addition, current law permits DHFS to use MA targeted case management moneys to provide services to children and families in Milwaukee County and to use income augmentation services receipts for other purposes if the secretary of administration and JCF, under a 14-day passive review process, approve a plan submitted by DHFS for the proposed use of those moneys.

Also under current law, there is appropriated to DHFS all moneys received from the federal government that are intended to reimburse the state for expenditures in previous fiscal years and that exceed the amount of those moneys estimated to be received (excess federal revenues). Currently, DHFS is authorized to expend those excess federal revenues for liabilities anticipated to be paid with federal moneys, but that are not allowable uses of federal moneys (federal disallowances).

This bill permits DHFS in fiscal year 2007-08 and the Department of Children and Families (DCF) in fiscal year 2008-09 to expend not more than $500,000 in income augmentation services receipts, MA targeted case management moneys, and excess federal revenues received in fiscal year 2006-07 or 2007-08 for unexpected or unusually high-cost out-of-home care placements of Indian children ordered by tribal courts if DHFS or DCF determines in light of overall child welfare needs and after paying federal disallowances that there are sufficient income augmentation services receipts, MA targeted case management moneys, and excess federal revenues to expend for that purpose.

***** ANALYSIS FROM -1314/2 *****

HEALTH AND HUMAN SERVICES

CHILDREN

This bill requires DWD to study the efficiency of the current method used in Wisconsin for collecting child support and the feasibility of using, and the efficiency of, other methods of collection and to submit its findings and recommendations to the secretary of DOA by December 1, 2008.

***** ANALYSIS FROM -1609/2 *****

HEALTH AND HUMAN SERVICES

HEALTH

Under current law, DHFS administers a program under which individuals with a human immunodeficiency virus (HIV) infection may receive reimbursement for the

cost of the drug azidothymidine (AZT) or other cost-effective alternatives. DHFS also administers a program under which individuals with an HIV infection may have health insurance premiums subsidized if they are on unpaid medical leave, or have had to discontinue their employment or reduce their hours, because of a medical condition arising from or related to the HIV infection. This bill requires DHFS to conduct a three-year pilot program under which DHFS may pay premiums for coverage under the Health Insurance Risk-Sharing Plan (HIRSP), and copayments under HIRSP for drugs eligible for reimbursement under the AZT-reimbursement program, for up to 100 individuals at any given time who: 1) are eligible for the AZT-reimbursement program; 2) do not have health insurance coverage; and 3) are not eligible for the health insurance premium subsidy program because they are not on unpaid medical leave and have not had to discontinue employment or reduce hours because of their medical condition. HIRSP is, generally, a health insurance program administered by the HIRSP Authority that provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for HIV, and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health conditions.

"/P1"→"/P2"

***** ANALYSIS FROM -0248/3 *****

HEALTH

Currently, DHFS administers the Well-Woman Program, under which certain medical services related to breast cancer, cervical cancer, and multiple sclerosis and certain general medical services are provided to underinsured and uninsured women of low income.

This bill requires health insurers, self-insured plans, service benefits plans, and pharmacy benefits managers (third parties) to provide to DHFS information from their records to enable DHFS to identify persons receiving benefits under the Well-Woman Program who are eligible, or would be eligible as dependents, for health care coverage from a third party. These third parties may receive compensation for providing the information, must provide the information within certain deadlines, and may be subject to enforcement proceedings for noncompliance. The third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under the Well-Woman Program has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after

the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

***** ANALYSIS FROM -1006/3 *****

HEALTH AND HUMAN SERVICES

HEALTH

Under current law, the Health Insurance Risk-Sharing Plan Authority (HIRSP Authority) administers the Health Insurance Risk-Sharing Plan (HIRSP), which provides health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, and persons who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage (creditable coverage) for at least 18 months in the past. HIRSP is funded by premiums paid by covered persons, insurer assessments, and provider payment discounts.

This bill makes the following changes to HIRSP and the HIRSP Authority:

1. The bill provides that the HIRSP Authority is to be treated as a state agency for all purposes under the Wisconsin Retirement System, including the purpose of providing fringe benefits, such as participation in the pension plan and health insurance coverage, to its employees.

2. The bill requires the Investment Board, if requested by the HIRSP Authority, to invest funds of the HIRSP Authority in the state investment fund. The bill further permits the HIRSP Authority to participate in the local government pooled-investment fund.

3. Currently, insurer assessments and federal high risk pool grant moneys are paid to OCI and then to the HIRSP Authority. Under the bill those payments go directly to the HIRSP Authority.

4. Currently, for payment under HIRSP, all providers of services and articles must be certified to provide those services and articles under the Medical Assistance (MA) program. The bill allows prescription drugs to be provided by a network of pharmacists and pharmacies that are approved by the HIRSP Authority Board of Directors. The network, however, must include all pharmacists and pharmacies that are certified to provide prescription drugs under MA in this state.

5. Currently, payments to providers must consist of the allowable charges for services and articles under MA with an enhancement determined by the HIRSP Authority. The adjustments must take into account provider discounts. The bill requires payments to providers to consist of usual and customary payment rates, determined by the HIRSP Authority, with adjustments that take into account provider discounts.

6. The bill provides that any administrator with which the HIRSP Authority Board contracts to administer HIRSP must also be the administrator of the Health Coverage Tax Credit Program, which the HIRSP Authority is required under current law to design and administer.

7. Under current law, certain persons with coverage under HIRSP with incomes below a specified level are eligible for premium and deductible subsidies. The bill makes all persons with coverage under HIRSP with incomes below that specified level eligible for the premium and deductible subsidies.

8. Under current law, with certain exceptions, anyone who is eligible for certain types of health care coverage provided by an employer is ineligible for coverage under HIRSP. The bill authorizes the HIRSP Authority Board to specify other exceptions.

***** ANALYSIS FROM -1549/1 *****

HEALTH AND HUMAN SERVICES

HEALTH

Currently, DHFS subsidizes the premium costs for health insurance coverage, except for premiums for the federal Medicare program (Medicare), of low-income persons who have HIV infections and are unable to continue employment or must reduce employment hours because of illnesses or medical conditions arising from the HIV infections. Medicare has programs of coverage for hospital care, physicians' services, and prescription drugs.

This bill changes the restriction on subsidization by DHFS of Medicare premiums to allow subsidization for premiums for Medicare prescription drug coverage, for low-income persons with HIV infections, no or reduced employment, and HIV-related illnesses or medical conditions.

***** ANALYSIS FROM -1550/1 *****

HEALTH AND HUMAN SERVICES

HEALTH

Currently, DHFS distributes numerous grants for community programs.

This bill requires DHFS to distribute at least $167,000 in each fiscal year as a grant to an organization to provide services to consumers and providers of supportive home care and personal care.

***** ANALYSIS FROM -1471/2 *****

HEALTH AND HUMAN SERVICES

HEALTH

This bill changes the funding source for an appropriation account for emergency medical services from the general fund to the transportation fund.

*** ANALYSIS FROM -0332/4 ***
HEALTH AND HUMAN SERVICES

MENTAL ILLNESS AND DEVELOPMENTAL DISABILITIES

Under current law, intermediate care facilities for the mentally retarded (ICF-MRs) must pay the state an assessment on each licensed bed. The assessment is currently $445 per month per bed. Federal law provides for a reduction in federal funding for MA if the state collects an amount in ICF-MR bed assessments that exceeds a specified portion of the aggregate revenues of all ICF-MRs in the state.

This bill directs DHFS to determine the amount of the ICF-MR bed assessment for each state fiscal year. DHFS must set the monthly per bed assessment amount at 5.5 percent of projected aggregate annual revenues for ICF-MRs in the state divided by the number of licensed ICF-MR beds and by 12 months. The bill authorizes DHFS to reduce the assessment amount during a state fiscal year to avoid collecting an amount during the year that exceeds 5.5 percent of ICF-MR aggregate revenues.

Current law provides a procedure under which a nursing home may request, and DHFS may approve, a temporary reduction in the number of beds licensed for the nursing home, if DHFS establishes a minimum per patient day occupancy standard for nursing homes and the nursing home's occupancy rate falls below that standard. If the nursing home does not resume licensure of the affected beds, DHFS must incrementally revoke licensure for the affected beds. This bill repeals this procedure for reducing a nursing home's number of licensed beds when the nursing home's occupancy rate falls below an occupancy standard established by DHFS.

***** ANALYSIS FROM -0248/3 *****

OTHER HEALTH AND FAMILY SERVICES

Currently, DHFS administers Family Care, a program that provides a flexible benefit of long-term care and services to certain persons who are at least 18 years of age, meet functional and financial eligibility requirements, and have a physical or developmental disability or degenerative brain disorder.

This bill requires health insurers, self-insured plans, service benefits plans, and pharmacy benefits managers (third parties) to provide to DHFS information from their records to enable DHFS to identify persons receiving benefits under Family Care who are eligible, or would be eligible as dependents, for health care coverage from a third party. These third parties may receive compensation for

providing the information, must provide the information within certain deadlines, and may be subject to enforcement proceedings for noncompliance. The third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under Family Care has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

Under current law, DHFS may request from health insurers information to enable DHFS to identify Medical Assistance recipients who are eligible, or who would be eligible as dependents, for health insurance coverage. An insurer that receives a request must provide the information within a certain period of time. Under the bill, DHFS must provide any information that it receives from a health insurer, self-insured plan, service benefit plan, and pharmacy benefits manager to DWD for purposes of DWD's program related to child and spousal support, paternity establishment, and medical support liability. DWD may allow county and tribal child support agencies access to the information, subject to use and disclosure restrictions under current law, and must consult with DHFS regarding procedures to safeguard the confidentiality of the information.

***** ANALYSIS FROM -1022/3 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

This bill requires DHFS to seek waivers for federal medical assistance laws that are necessary to implement, in at least three pilot sites, a Medical Assistance Program under managed care for the long-term care of children with disabilities. The bill also requires DHFS to award moneys in both years of the fiscal biennium for technical assistance and planning services in support of family-centered managed care for children with long-term support needs.

*** ANALYSIS FROM -0358/3 ***
HEALTH AND HUMAN SERVICES

HEALTH

Under current law, under the Long-Term Care Ombudsman Program, the long-term care ombudsman or his or her designated representative may enter a long-term care facility at any time, without notice, and have access to clients and residents of the facility. "Long-term care facility" is defined as a nursing home, a community-based residential facility, a place in which care is provided under a continuing care contract, a swing bed in an acute care or extended care facility, or an adult family home. The ombudsman or representative may communicate in private with a client or resident, review records with consent of the client or resident or his

or her legal counsel, and have access to records of the long-term care facility or of the DHFS concerning regulation of the long-term care facility.

Also under current law, residential care apartment complexes are certified or registered and otherwise regulated by DHFS. A "residential care apartment complex" is defined as a place where five or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen with a stove, and individual bathroom, sleeping, and living areas, and that provides to a resident not more than 28 hours per week of supportive, personal, and nursing services.

Current law specifies rights of residents of nursing homes and community-based residential facilities, including the rights to have private and unrestricted communication with others, to present grievances without justifiable fear of reprisal, and to be fully informed of all services, charges for services, and changes in service.

Lastly, current law authorizes the Board on Aging and Long-Term Care (BOALTC) to contract to provide advocacy services to potential or actual recipients of the Family Care Program, or their families or guardians.

This bill expands the definition of a long-term care facility, for purposes of activities by the long-term care ombudsman or his or her designated representative, to include residential care apartment complexes.

The bill also includes residents of residential care apartment complexes as persons entitled to the rights that are specified under current law for residents of nursing homes and community-based residential facilities.

The bill requires a residential care apartment complex to post in a conspicuous location a notice of the name, address, and telephone number of the Long-Term Care Ombudsman Program.

Finally, the bill authorizes BOALTC to employ staff within the classified service to provide advocacy services to Family Care Program recipients or potential recipients, their families, and guardians.

***** ANALYSIS FROM -0332/4 *****

MENTAL ILLNESS AND DEVELOPMENTAL DISABILITIES

Under current law, intermediate care facilities for the mentally retarded (ICF-MRs) must pay the state an assessment on each licensed bed. The assessment is currently $445 per month per bed. Federal law provides for a reduction in federal funding for MA if the state collects an amount in ICF-MR bed assessments that exceeds a specified portion of the aggregate revenues of all ICF-MRs in the state.

*** ANALYSIS FROM -0878/5 ***

HEALTH AND HUMAN SERVICES

MENTAL ILLNESS, ALCOHOLISM, AND DEVELOPMENTAL DISABILITIES

Currently, the Council on Developmental Disabilities is attached to DHFS and performs numerous duties, including developing, approving, and continuing modification of the statewide plan for delivery of services to individuals with developmental disabilities. The Council on Developmental Disabilities is funded, in part, by a federal grant.

This bill transfers the Council on Developmental Disabilities to DOA and creates an appropriation in DOA for receipt and distribution of federal moneys for the Council on Developmental Disabilities. The bill requires DHFS to ensure that the matching funds requirement under the federal grant that provides funds for the Council on Developmental Disabilities is met by reporting expenditures made for the provision of developmental disabilities services under the Community Aids Program.

*** ANALYSIS FROM -0247/1 ***

HEALTH AND HUMAN SERVICES

MENTAL ILLNESS, ALCOHOLISM, AND DEVELOPMENTAL DISABILITIES

Currently, DHFS administers a fund, known as the "group home revolving loan fund," to make limited two-year loans to applying nonprofit organizations to

establish housing programs for individuals who are recovering from alcohol or other drug abuse. This bill eliminates the group home revolving loan fund.

***** ANALYSIS FROM -0892/11 *****

OTHER HEALTH AND HUMAN SERVICES

Currently, DHFS administers a grant program for statewide tobacco use control that funds programs to prevent, reduce, or cease tobacco use. Also under current law, a trust fund designated as the permanent endowment fund exists that consists of proceeds from the sale of the state's right to receive payments under a master tobacco settlement agreement and investment earnings on the proceeds.

This bill establishes a trust fund designated as the health care quality fund, from moneys obtained by increasing cigarette and other tobacco products taxes, by transferring funds from the permanent endowment fund, and from certain other sources. Under the bill, moneys from the health care quality fund are appropriated in part for the statewide grant program for tobacco use control and for health care quality and patient safety information.

***** ANALYSIS FROM -1548/2 *****

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

Under current law, DHFS, which administers the Medical Assistance (MA) program, may recover incorrect payments that were made for health care services

under MA that resulted from a misstatement or omission of fact by a person supplying information in an application for benefits, from the failure of a person to report the receipt of income or assets in an amount that would have affected a recipient's eligibility for benefits, or from the failure of a person to report changes in a recipient's financial or nonfinancial situation or eligibility characteristics that would have affected the recipient's eligibility for benefits or his or her cost-sharing requirements. If DHFS provides any medical assistance to a person as a result of an injury, for example, that was caused by a third party, DHFS may recover from the third party the amount of the medical assistance provided. Also under current law, if an individual who is obligated to pay court-ordered child or family support or maintenance (support) has an overdue support obligation because of a failure to pay, his or her name, social security number, and amount of support owed is posted on a statewide support lien docket.

This bill requires every insurer authorized to do business in this state, before paying any claim of $500 or more, to verify with DHFS that the individual to whom the claim is to be paid does not owe an amount that was paid under MA incorrectly (medical assistance liability) and to check the statewide support lien docket to ensure that the individual does not have an overdue support obligation (support liability).

If the individual has a support liability, the insurer must pay the claim proceeds, up to the amount of the support liability, to DWD. If the individual has a medical assistance liability, the insurer must pay the claim proceeds, up to the amount of the medical assistance liability, to DHFS. If the individual has both liabilities, the support liability must be paid first. After any liability is paid, the individual is paid any claim proceeds that remain.

***** ANALYSIS FROM -1508/3 *****

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

Currently, except for issuance of certain birth certificates, the state registrar or a local registrar must charge $7 for issuing a certified or uncertified copy of a certificate of birth, death, divorce or annulment, or marriage (vital record) or for verifying information about the event without issuing a copy, and $3 for issuing any additional copy of the same vital record at the same time. This bill increases to $20 the fee for issuance of a certified or uncertified copy of certain vital records, increases to $20 the fee for issuing an additional copy at the same time, increases to $10 the fee for verifying information about the event without issuing a copy, and increases to $10 the fee for issuing an additional copy of the same vital record at the same time.

Currently, the state registrar or a local registrar must charge $12 for issuing either a certified copy or an uncertified copy of a birth certificate and $3 for issuing, at the same time, any additional certified or uncertified copy of the same birth certificate. Of the $12 charged, $7 must be forwarded to the secretary of administration for deposit in program revenue appropriations for the Child Abuse and Neglect Prevention Board (CANPB), to be used for CANPB expenses, for certain statewide projects, for the Family Resource Center Grant Program, and for technical assistance to organizations. The bill increases the fee for issuance of a certified or uncertified copy of a birth certificate from $12 to $20, and increases, from $7 to $10, the amount that must be forwarded to the secretary of administration for deposit in program revenue appropriation accounts of CANPB. The bill also increases the fee for issuance of an additional certified or uncertified birth certificate copy from $3 to $20.

Currently, the state registrar or a local registrar must charge $10 for issuing one certified copy of a birth certificate for a birth resulting in stillbirth and $3 for any additional certified copy of the same birth certificate; the bill changes these fees to $20 each.

Currently, the state registrar or a local registrar must charge, in addition to other applicable fees, $10 for expedited service in issuing a vital record; bill changes this fee to $20.

Currently, the state registrar or a local registrar may charge $7 to search vital records if the registrar finds no record and an additional $7 if the requester provides no or little information. The bill increases to $10 the fee to search vital records and the fee if the requester provides no or little information.

The bill requires local registrars to forward to the secretary of administration, for credit to a program revenue appropriation account within DHFS, 60 percent of all revenue generated by fee increases for issuance of copies of vital records, other than divorce records. From these moneys, the bill requires DHFS to transfer $1,250,000 in each fiscal year from this program revenue appropriation account to an appropriation account for local assistance; from this appropriation account, DHFS must distribute $1,000,000 in each fiscal year for domestic abuse services and $250,000 in each fiscal year to Milwaukee County to organizations to provide gender-responsive alcohol and other drug abuse services and other services to drug dependent women with children. The bill also requires DHFS to transfer $500,000 in each fiscal year from the program revenue appropriation account to an

appropriation account for interagency and intra-agency local assistance; from this appropriation account, DHFS must distribute $500,000 in each fiscal year for comprehensive early childhood initiatives in Dane County for low-income families.

Currently, the state registrar must charge $10 for making selected amendments to birth records without a court order, making court-ordered corrections to birth certificates, making any change in a birth certificate such as acknowledgment of paternity, and for making court-ordered name changes. The state registrar must charge $20 for registering certain new or corrected vital records and $25 for late registration of birth certificates. The bill changes these required fee amounts to the following:

1. Twenty dollars for amending birth records for voluntary acknowledgment of paternity and for a legal name change within 365 days after birth.

2. Forty dollars for selected amendments to birth records without a court order; court-ordered amendments to certain vital records; court-ordered adjudications of paternity or determinations of paternity after death; delayed acknowledgments of paternity; legal name changes; and impounding a vital record or creating and registering a new vital record under certain circumstances.

3. Fifty dollars for the delayed filing of certain birth, marriage, or death certificates.

***** ANALYSIS FROM -0904/2 *****

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

This bill creates a health care quality and patient safety council, attached to DHFS, which must, among other things, consider the most cost-effective means of implementing a statewide integrated or interoperable health care information system.

Under current law, the Wisconsin Health and Educational Facilities Authority (WHEFA) provides financial assistance to health facilities and participating health institutions. This bill prohibits WHEFA from providing such financial assistance unless the health facility or participating health institution seeking assistance demonstrates to the secretary of health and family services progress in improving medical information systems technology. In making a determination as to whether the progress is demonstrated, the secretary of health and family services must consider advice of the health care quality and patient safety council.

***** ANALYSIS FROM -1589/3 *****

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

Under current law, a person who is obligated to pay child or family support must pay an annual fee of $35 to DWD for receiving and disbursing the child support funds to the person who receives the child or family support. This bill increases that annual receipt and disbursement fee to $65 and requires DWD to collect an annual fee of $25 from a person receiving child or family support in addition to the fee paid by the person paying the support.

*** ANALYSIS FROM -0260/1 ***

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

Under current law, DHFS distributes general purpose revenues and federal revenues, as community aids, to counties to provide social, mental health, developmental disabilities, and alcohol and other drug abuse services. Current law requires each county, before December 1 of each year, to submit to DHFS a proposed budget for the expenditure of the community aids funds allocated to that county. This bill eliminates that requirement.

*** ANALYSIS FROM -0647/3 ***

OTHER HEALTH AND HUMAN SERVICES

Under current law, the maximum number of licensed nursing home beds statewide is 51,795. A nursing home may transfer a licensed bed to another nursing

home only under certain conditions, including if the transferring and receiving nursing homes are within the same bed allocation area, as determined by DHFS, or if the receiving nursing home is located in a county that adjoins the bed allocation area of the transferring nursing home.

This bill reduces the statewide licensed nursing home bed cap to 42,000 beds and changes the limitation on transferring a licensed bed from one nursing home to another to require that the receiving nursing home be in the same bed allocation area or in an adjoining area.

***** ANALYSIS FROM –1272/5 *****

INSURANCE

This bill creates the Healthy Wisconsin Authority (HWA). An authority is a public body corporate and politic with a board of directors that is created by state law but that is not a state agency. The board of directors of HWA consists of the commissioner of insurance, or the commissioner's designee, as a nonvoting member and 13 other members who will serve four–year terms, including a majority party senator and a majority party representative to the assembly, appointed by the senate majority leader and the speaker of the assembly, respectively, and a minority party senator and a minority party representative to the assembly, appointed by the senate minority leader and the assembly minority leader, respectively. Nine other members

are nominated by the governor and appointed with the advice and consent of the senate and consist of a health care provider and representatives of a health insurance company, a small employer, Wisconsin labor unions, health benefit purchasing cooperatives, and the public interest. The board must appoint an executive director, who may not be a member of the board.

Because HWA is not a state agency, numerous laws that apply to state agencies do not apply to HWA. However, HWA is treated like a state agency in the following respects, among others: 1) it is generally subject to the open records and open meetings laws; 2) it is treated like a state agency for purposes of the law regulating lobbying; 3) it is subject to state purchasing requirements and must use a competitive bid or proposal process whenever contracting for services; 4) it is exempt from income tax, sales and use tax, and property taxes; 5) the Code of Ethics for Public Officials and Employees covers HWA; 6) it is to be treated as a state agency for all purposes under the Wisconsin Retirement System; and 7) it is subject to auditing by the Legislative Audit Bureau.

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

management, and are hired outside the state hiring system; and 3) it is not subject to statutory rule–making procedures, including requirements for legislative review of proposed rules. Unlike most authorities under current law, HWA may not issue bonds.

HWA must study options and develop recommendations for implementing a reinsurance program to provide reinsurance to groups or individuals, or both, in the state for catastrophic claims under group or individual, or both, health insurance policies. By September 15, 2008, HWA must submit a report to the secretary of administration with its recommendations for implementing the reinsurance program. HWA must develop and administer any reinsurance program for which legislation is enacted that authorizes or requires HWA to do so. HWA may contract with a vendor to administer any reinsurance program that is implemented, and must contract with an independent entity for annual program and financial evaluations of an implemented reinsurance program. HWA may make recommendations to the governor on the impact of allowing health benefit purchasing cooperatives to participate in any implemented reinsurance program and on proposals to reduce health insurance premiums for American Indian tribes and bands in the state and other sectors of the group health insurance market. HWA may explore other ways

to lower health care costs, including considering options for comprehensive health care reform. The bill also appropriates initial and operating costs to HWA from the health care quality fund, which is created in the bill and funded with moneys obtained from an increase in cigarette and other tobacco products taxes and certain other sources.

***** ANALYSIS FROM –1561/1 *****

INSURANCE

Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of 1) the expenses of 30 days of inpatient services, or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance

policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on the basis of the change in the consumer price index for medical services since the coverage amounts in current law were enacted in 1985 and 1992. Inpatient services must be covered in the minimum amount of the lesser of 1) the expenses of 30 days of inpatient services; or 2) $20,250 minus the applicable cost sharing or, if

there is no cost sharing under the policy, $18,250 in equivalent benefits measured in services rendered. Outpatient services must be covered in the minimum amount of $3,450 minus the applicable cost sharing or, if there is no cost sharing under the policy, $3,100 in equivalent benefits measured in services rendered. Transitional treatment arrangements must be covered in the minimum amount of $5,200 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,650 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $20,250, or the equivalent benefits measured in services rendered, in a policy year.

The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on

the increase in the federal cost–of–living for medical coverage "indexed" since the enactment of the current coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost–sharing	$7,000*	1985	$20,250*
No cost–sharing	$6,300	1985	$18,250
Outpatient			
Cost–sharing	$2,000*	1992	$ 3,450*
No cost–sharing	$1,800	1992	$ 3,100
Transitional			
Cost–sharing	$3,000*	1992	$ 5,200*
No cost–sharing	$2,700	1992	$ 4,650
All services	$7,000	1985	$20,250

*Minus cost–sharing

The bill also requires DHFS to report annually to the governor and legislature on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs.

***** ANALYSIS FROM –1553/P2 *****

INSURANCE

insert PJK (next page)

This bill requires health insurance policies and self–insured governmental and school district health plans to cover the cost of treatment for an insured for autism, Asperger's syndrome, and pervasive developmental disorder not otherwise specified if the treatment is provided by a psychiatrist, a psychologist, or a social worker who

is certified or licensed to practice psychotherapy. A policy or plan is not required to cover more than four hours of treatment per month, however. The coverage requirement applies to both individual and group health insurance policies and plans, including defined network plans and cooperative sickness care associations; to health care plans offered by the state to its employees, including a self–insured plan; and to self–insured health plans of counties, cities, towns, villages, and school districts. The requirement specifically does not apply to limited–scope benefit plans, medicare replacement or supplement policies, long–term care policies, or policies covering only certain specified diseases. The coverage may be subject to any limitations or exclusions or cost–sharing provisions that apply generally under the policy or plan.

***** ANALYSIS FROM –1457/3 *****

INSURANCE

Under current law, an insurer may not restrict or terminate coverage for chiropractic treatment under a health insurance policy that covers chiropractic treatment except on the basis of an examination or evaluation by, or the recommendation of, a chiropractor or a peer review committee (independent evaluation). If, on the basis of an independent evaluation, the insurer restricts or terminates a patient's coverage for chiropractic treatment and the patient then

becomes liable for payment of the treatment, the insurer must provide to the patient and the treating chiropractor a written statement that includes, among other things, a reasonable explanation of the factual basis for the restriction or termination of coverage. Under this bill, the written statement must provide a detailed, rather than merely reasonable, explanation of the clinical rationale, rather than the factual basis, for the restriction or termination of coverage. The bill also provides that, if an insurer restricts or terminates an insured's coverage for treatment, not limited to chiropractic treatment, and as a result the insured becomes liable for all of the cost of the treatment, the insurer must provide on the explanation of benefits form a detailed explanation of the clinical rationale and the basis in the policy or applicable law for the restriction or termination of coverage.

Current law does not regulate the use of current procedural terminology codes (numbers on a health insurance claim form that indicate the services that a health care provider performed). This bill requires an insurer who changes the current procedural terminology code that the health care provider put on the health insurance claim form to include on the explanation of benefits form the reason for the change and to cite the source for the change.

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*** **ANALYSIS FROM –0450/1** ***

LPS: copy of p. 37 attached.

This bill establishes a trust fund designated as the health care quality fund, from moneys obtained by increasing cigarette and other tobacco products taxes, by transferring funds from the permanent endowment fund, and from certain other sources. Under the bill, moneys from the health care quality fund are appropriated in part for the statewide grant program for tobacco use control and for health care quality and patient safety information.

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*** ANALYSIS FROM -0892/11 ***

INSURANCE

Under current law, certain health care providers are required to carry health care liability insurance with liability limits of at least $1,000,000 for each occurrence and at least $3,000,000 for all occurrences in a policy year. Any portion of a medical malpractice claim against a health care provider subject to the health care liability insurance requirements that exceeds the policy limits of the health care provider's health care liability insurance is paid by the injured patients and families compensation fund. Moneys for the fund come from annual assessments paid by the health care providers who are subject to the health care liability insurance requirements. This bill transfers $175,000,000 in fiscal year 2007-08 from the injured patients and families compensation fund to the health care quality fund, as created in the bill.

↑ move to p. 157 after analysis from -1457/3 LRB 1780/P1

JUSTICE

This bill gives the DOJ the authority to bring an action for injunctive or other equitable relief against a person who interferes with the exercise or enjoyment by an individual of a right secured by the constitution or laws of this state or of the United States.

*** ANALYSIS FROM –1537/4 ***

JUSTICE

Under current law, the Crime Victim Compensation program requires DOJ to compensate victims of certain crimes, their caretakers, and, in cases in which the victim dies, their family members, for medical expenses, lost wages, funeral and burial expenses, and other expenses that result from the victim's injury or death. DOJ may not compensate a victim who has not cooperated with appropriate law enforcement agencies. Any compensation that DOJ provides must be reduced by any insurance payments received, or to be received, as a result of the crime.

This bill creates the Sexual Assault Forensic Examination program to compensate, under limited circumstances, a health care provider who examines a victim of a sex offense for the costs of the examination, any procedure that tests for or prevents a sexually transmitted disease, and any medication to prevent or treat a sexually transmitted disease (examination costs). If the victim does not authorize

the health care provider to seek payment from insurance or another program, DOJ must compensate the health care provider for the examination costs, regardless of whether the victim cooperates with a law enforcement agency. If the victim does authorize the health care provider to seek payment from insurance or another program, DOJ must compensate the health care provider for the examination costs, reduced by any payment from insurance or another program, only if the victim refuses to cooperate with a law enforcement agency.

***** ANALYSIS FROM –1315/2 *****

JUSTICE

OTHER JUSTICE

Under current law, a firearms dealer must request that DOJ perform a firearms restrictions record search on a handgun purchaser before the dealer may complete a sale of a handgun to the purchaser. DOJ charges firearms dealers $8 for each record search. This bill increases the fee for a firearms restrictions record search to $30.

***** ANALYSIS FROM –1577/2 *****

JUSTICE

Under current law, most persons who are ordered by a state or municipal court to pay a fine or forfeiture must also pay a penalty surcharge equal to 26 percent of the fine or forfeiture. The penalty surcharge receipts are appropriated to DOJ to fund a variety of activities, services, and equipment, including training for law

Ins into page 159 of 1780/P1:

Under current law, most people who are ordered by a state or municipal court to pay a fine or forfeiture must also pay a penalty surcharge equal to 26 percent of the fine or forfeiture. The penalty surcharge receipts are appropriated to DOJ to fund a variety of activities, services, and equipment, including training for law enforcement and correctional officers, enforcement of drug laws, services for crime victims, and information systems for law enforcement. The bill increases the penalty surcharge to 27 percent of fines or forfeitures.

Also under current law, a firearms dealer must request that DOJ perform a firearms restrictions record search on a handgun purchaser before the dealer may complete a sale of a handgun to the purchaser. DOJ charges firearms dealers $8 for each record search, and the fee revenues are appropriated to DOJ to conduct the record searches. The bill increases the firearms restrictions record search fee to $30. The bill further provides that revenues from the record search fee be deposited in the same appropriation account as penalty surcharge receipts and that record searches be funded from that appropriation account.

enforcement and correctional officers, enforcement of drug laws, services for crime victims, and information systems for law enforcement. Also under current law, firearms dealers must pay DOJ a fee for conducting firearms restrictions record searches on handgun purchasers. The firearms restrictions record search fee receipts are appropriated to DOJ for firearms restrictions record searches.

This bill increases the penalty surcharge to 27 percent of fines or forfeitures. The bill also provides that firearms restrictions record search fees must be deposited in the appropriation account in which penalty surcharge receipts are deposited and that firearms records restriction searches must be funded from this appropriation.

***** ANALYSIS FROM –1170/5 *****

LOCAL GOVERNMENT

Current law prohibits a political subdivision (any city, village, town, or county) from increasing its levy by a percentage that exceeds its "valuation factor," which is defined as the percentage change in the political subdivision's equalized value due to new construction, less improvements removed, but not less than 2 percent. In addition, the calculation of a political subdivision's levy does not include any tax increment that is generated by a tax incremental district.

Current law contains exceptions to the levy limit for political subdivisions that transfer the provision of services, for cities or villages that annex town territory, for

political subdivisions that levy to pay debt service on debt authorized by referendum on or after July 1, 2005, for certain joint fire departments, and for a county levy that relates to a county children with disabilities education board.

Also under current law, a political subdivision's levy limit is increased if the amount of debt service in the current year exceeds the amount in the prior year for debt that was approved by the governing body before July 1, 2005. The levy limit may also be exceeded if a political subdivision's resolution to do so is approved in a referendum. If a political subdivision exceeds the levy limit, creating a "penalized excess," DOR is required to reduce the political subdivision's local aid payments in an equal amount. The levy limit only applies to the 2007 and 2008 levies.

This bill extends the levy limit on political subdivisions through 2009, modifies the calculation of the limit, and creates a number of new exceptions to the limit. The bill changes the definition of "valuation factor" to be the greater of either 4 percent or the percentage change in the political subdivision's equalized value due to new construction, less improvements removed. Also under the bill, the base amount of a political subdivision's levy, on which the levy limit is imposed, is the maximum allowable levy for the immediately preceding year.

The bill creates several new exceptions to the levy limit for political subdivisions: county levies for certain bridge and culvert construction and repairs; certain levies for fire departments from any combination of cities, villages, and towns that have entered into a contract to jointly provide fire protection services; political subdivision levies for a revenue short fall for the debt service on a revenue bond; and county levies for payments to adjacent counties for library services.

Under this bill, DOR may not reduce a political subdivision's aid payments unless its penalized excess is at least $500, but, if the amount of a political subdivision's penalized excess exceeds its aid payments in the following year, DOR must carry forward the unused penalized excess and deduct it from aid payments for future years until the penalized excess amount is fully deducted from local aid payments in future years. Also under the bill, a political subdivision will not be liable for a penalty for a penalized excess if DOR determines that the penalized excess is directly caused by DOR assessment errors or because of an error in preparing or delivering the tax roll by the taxation district clerk or county clerk.

***** ANALYSIS FROM –1169/P2 *****

LOCAL GOVERNMENT

This bill authorizes a county with a population of 500,000 or more (currently only Milwaukee County) to issue appropriation bonds on a one–time basis, other

than refunding bonds, to pay all or any part of the county's unfunded prior service liability with respect to an employee retirement system of the county. "Appropriation bonds" are defined as any bond, note, or other obligation of a county issued as provided in the bill to evidence the county's obligation to repay borrowed money that is payable from various sources, including the following:

1. Moneys annually appropriated by the county for debt service due with respect to the appropriation bonds.

2. Proceeds of the sale of the appropriation bonds.

3. Investment earnings on the items listed above.

Before the county may issue appropriation bonds, however, the county must enact an ordinance to implement a five–year strategic and financial plan related to the payment of unfunded employee retirement benefits. The financial plan shall provide that future annual pension liabilities are funded on a current basis, and the financial plan must contain quantifiable benchmarks to measure compliance with the plan. Annually, the county board must report to the legislature and the governor on a number of issues related to the appropriation bonds, including the county's progress in meeting the benchmarks.

The bill states that a populous county is not generally liable for appropriation bonds, and appropriation bonds are not a debt of the county for any purpose whatsoever. Appropriation bonds, including the principal and interest payments, are payable only from amounts that the county board may, from year to year, appropriate.

***** ANALYSIS FROM –1466/1 *****

LOCAL GOVERNMENT

Under current law, the Expenditure Restraint Program provides an annual state aid payment to any municipality that has a property tax rate greater than five mills and that limits the growth of its municipal budget according to a formula based generally on 60 percent of the percentage change in the equalized assessed value of new construction located in the municipality and on the rate of inflation.

This bill eliminates the Expenditure Restraint Program and replaces it with the Municipal Levy Restraint Program. The Municipal Levy Restraint Program provides annual state aid payments, beginning in 2009, to any municipality that has a property tax rate greater than five mills and that limits its property tax levy to an amount that is no greater than the maximum allowable levy according to a formula that is based generally on 60 percent of the percentage change in the equalized

assessed value of new construction located in the region in which the municipality is located and on the rate of inflation.

This bill also creates the County Levy Restraint Program, which provides annual state aid payments, beginning in 2009, to any county that limits its property tax levy to an amount that is no greater than the maximum allowable levy according to a formula that is based generally on 60 percent of the percentage change in the equalized assessed value of new construction located in the county and on the rate of inflation.

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***** ANALYSIS FROM –1468/2 *****

LOCAL GOVERNMENT

This bill increases the total amount of county and municipal aid to be distributed in 2008 so that the total amount of aid distributed in that year is the amount distributed in the previous year, plus $15,000,000. Each county and municipality receives an increased payment in proportion to its share of total county and municipal aid payments in 2007. In 2009 and subsequent years, the amount of each county's and municipality's payment is the same as the amount of its payment in 2008.

***** ANALYSIS FROM –1298/1 *****