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

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 *****

Under current law, the Health Insurance Risk-Sharing Plan Authority (HIRSP Authority) administers HIRSP, which provides health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for 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.

does all of

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

1. 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. Requires the Investment Board, if requested by the HIRSP Authority, to invest funds of the HIRSP Authority in the state investment fund and permits the HIRSP Authority to participate in the local government pooled-investment fund.

3. Allows prescription drugs to be provided under HIRSP by a network of pharmacists and pharmacies that are approved by the HIRSP Authority Board of Directors.

4. Requires payments to providers under HIRSP to consist of usual and customary payment rates instead of the allowable charges for services and articles under MA.

5. Expands eligibility for premium and deductible subsidies to all persons with coverage under HIRSP with incomes below a specified level.

INSERT FROM pp. 92-98

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

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 separate programs of coverage for hospital care,

physicians' services, and prescription drugs. This bill authorizes DHFS to subsidize the premium costs for Medicare prescription drug coverage for these persons.

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

~~Currently, DHFS distributes numerous grants for community programs.~~ This bill requires DHFS to ~~distribute~~ award a grant of at least $167,000 in each fiscal year ~~as a grant~~ to an organization to ~~provide~~ for services to consumers and providers of supportive home care and personal care.

***** ANALYSIS FROM -1716/1 *****

LONG-TERM CARE

Under current law, DHFS administers a variety of long-term care programs for people who are aged or have a disability. Under the Community Options Program (COP), Community Options Waiver Program (COP Waiver), and the Community Integration Program for people who are relocated or diverted from nursing homes (CIP II), counties provide community-based long-term care services to persons who are aged or have a physical or developmental disability and qualify for ~~Medical Assistance~~ MA. A number of counties have implemented the Family Care program to provide long-term care services for a capitated payment rate and information and referrals related to long-term care options. Finally, in several counties, organizations administer the Wisconsin Partnership Program or the Program for All-Inclusive Care for the Elderly (PACE), capitated payment rate programs to

provide both long-term care and acute health care services to elderly people or people with physical disabilities who are eligible for nursing home care.

Current law requires that DHFS obtain approval from ~~the Joint Committee on Finance~~ before expanding use of capitated rate payment programs to provide long-term care services. ~~The~~ bill eliminates this requirement.

Under ~~the~~ Family Care, DHFS contracts with resource centers to provide information to ~~any~~ interested individual regarding long-term care services and to determine eligibility for the family care benefit. DHFS contracts with care management organizations (CMOs) to provide the family care benefit to eligible people for a capitated monthly rate. CMOs must provide a variety of services under the family care benefit including supportive living, personal care, supported employment, and home health services, as well as nursing home and other institutional care.

~~The eligibility requirements~~ for the family care benefit ~~are as follows:~~ a person must be at least 18 years of age; have a physical or developmental disability or a degenerative brain disorder (a qualifying condition); have a long-term or irreversible condition and be in need of ongoing care or require care in order to maintain independence or functional capacity (functional eligibility); and either be

eligible for ~~Medical Assistance~~ MA or have projected care costs that exceed a specified portion of income and assets (financial eligibility).

Currently, five counties have both a resource center and a CMO, and an additional four counties have only a resource center. Before DHFS contracts with an entity to operate ~~either~~ a resource center or a CMO in a county or for a tribe, the county or tribe must appoint a local long-term care council and the council must develop a plan concerning whether and how to implement Family Care ~~in the county or for the tribe~~. A single entity may not operate both a resource center and a CMO. A county, alone or with other counties, may create a special purpose district called a family care district that is independent of the county to operate either a resource center or a CMO, and a tribe may ~~also~~ establish a corporation that is separate from the tribe to operate a resource center or a CMO.

The bill makes changes to Family Care, ~~including the following~~: the following

1. ~~Currently,~~ The bill eliminates the requirement that DHFS ~~must~~ obtain approval from ~~the Joint Committee on Finance~~ JCF before entering into a new contract for a resource center or a CMO, and before entering into a contract with a private entity to operate a CMO. ~~The bill eliminates these requirement~~ This is no longer required.

2. Currently, DHFS may only make the family care benefit available in areas of the state in which, in the aggregate, not more than 50 percent of the population that is eligible for the family care benefit resides. The bill repeals this cap on the proportion of the state in which CMOs may be established.

3. Currently, the family care benefit is an entitlement for people who are eligible for family care and eligible for Medical Assistance (MA). By January 1, 2008, DHFS must extend entitlement for the family care benefit to certain persons who are not MA eligible. The bill requires that a person be eligible for MA to receive the family care benefit, and thus eliminates the requirement that DHFS extend, by January 1, 2008, entitlement for the family care benefit to people who are not eligible for MA. However, the bill provides that people who are not eligible for MA but are receiving the family care benefit on the date this bill is enacted continue to be eligible for, but not entitled to, the family care benefit.

4. The bill renames a family care district a long-term care district and provides for tribes acting in conjunction with counties, other tribes, or alone to create a long-term care district. The bill allows a long-term care district to operate the Wisconsin Partnership Program or PACE, as long as the district does not also operate a resource center. The bill also does the following: modifies provisions governing

membership of long-term care district boards; modifies compensation and benefit provisions relevant to former county employees who are hired by a long-term care district; specifies that counties are not responsible for providing or paying for any services that a long-term care district is required by statute or contract to provide or pay for; and provides for a county or tribe to withdraw or be removed from a long-term care district.

5. Currently, the local long-term care council for a county or tribe is required to review the performance of CMOs, identify gaps in services provided by the CMOs, develop strategies for increasing availability of needed long-term care services, advise the CMOs, monitor coordination between the resource center and CMOs, and perform long-range planning for the long-term care system, among other duties. The councils must report to DHFS annually on achievements and problems of the local long term-care system. The bill eliminates the councils and assigns some of their duties to the governing boards of resource centers and some to regional long-term care advisory committees, which are created in the bill.

The bill requires governing boards of resource centers, including assessing the availability and adequacy of long-term care services, reviewing coordination between the resource center and CMOs, monitoring complaints and appeals

regarding the local long-term care system, and developing strategies for increasing availability for long-term care services. The governing boards must report their findings to the appropriate regional long-term care committee.

The bill requires DHFS to establish regions for regional long-term care advisory committees. The governing body of each resource center must appoint a number of members specified by DHFS to serve on the appropriate regional long-term care committee. The duties of the committees include evaluating the performance of CMOs and resource centers, monitoring grievances and appeals regarding CMOs, reviewing utilization of long-term care services, identifying gaps in the availability of long-term care services, and performing long range planning for the regional long-term care system. ~~The committees must report to DHFS annually on achievements and problems of the regional long term-care system.~~

6. The bill eliminates degenerative brain disorder as a qualifying condition for the family care benefit, and instead provides that a person has a qualifying condition if he or she is "frail elder," ~~which is defined as~~ a person who is 65 years of age or older and ~~has~~ with a physical disability or irreversible dementia that restricts the individual's ability to perform ~~normal~~ daily tasks or that threatens the capacity ~~of the individual~~ to live independently.

7. Currently, a person may be functionally eligible for the family care benefit at one of two levels, comprehensive or intermediate. ~~The~~ This bill changes the two levels to nursing home level of care and non-nursing home level of care.

8. Currently, a CMO need not be licensed as a home health agency. ~~The~~ This bill provides that an entity with which a CMO contracts ~~to provide~~ home health services under Family Care need not be licensed as a home health agency ~~for purposes of providing~~ to provide the contracted services.

~~9.~~ Currently, if a county has a CMO, DHFS may allocate up to 21.3 percent of the county's basic community aids allocation to fund the services of the county's resource center and CMO. ~~The~~ 8. This bill changes the percentage of the county's basic community aids allocation that DHFS may allocate for this purpose to an amount agreed to by DHFS and the county.

INS. 94A

~~10.~~ 9. The bill provides that counties in which the family care benefit is available or in which the Wisconsin Partnership Program or PACE is operated may use their ~~Community Options Program~~ COP funding to provide mental health or substance abuse services or to provide services under the Family Support Program. Under the Family Support Program, counties provide services to families of children who are disabled to assist the families in caring for the children at home.

Under current law, community-based residential facilities (CBRFs) must assess the financial condition of privately paying clients prior to admission and provide them a statement that includes the estimated date on which the client would deplete his or her financial resources by paying for care in the facility. If that date is less that two years from the date of the statement, the CBRF must refer the client to the county department responsible for administering long-term care programs so that the county may assess the person's functional abilities, disabilities, and service needs and review alternatives to institutional care. Counties generally may not use COP, COP Waiver, or CIP II funds to pay for care in a CBRF unless the program recipient underwent such an assessment before he or she entered the CBRF, regardless of whether the recipient entered the CBRF as a privately paying client. The bill repeals the requirement that CBRFs assess the financial condition of privately paying clients prior to admission and the restriction on using COP, COP Waiver, or CIP II funds to pay for care in a CBRF for a program recipient who did not undergo an assessment of his or her abilities, disabilities, and services needs and a review of alternatives to institutional care before entering the CBRF.

Under current law, CBRFs, residential care apartment complexes (RCACs), nursing homes, and adult family homes in counties that have Family Care resource

centers must provide prospective residents information about resource centers and the family care benefit and must refer certain prospective residents who are aged or who have a physical or developmental disability to the resource center. Hospitals in counties with resource centers also must refer certain patients who are aged or who have a physical or developmental disability to the resource center before discharging them.

The bill repeals the requirements that adult family homes provide information to prospective residents regarding resource centers and the family care benefit and refer prospective residents to the resource centers. The bill also repeals the requirement that hospitals refer patients to resource centers before discharging them. The bill ~~provides that~~ CBRFs and RCACs must provide information regarding resource centers and the family care benefit to prospective residents and, if a referral is required, refer prospective residents to resource centers when the CBRFs or RCACs first provide the prospective residents written material regarding their facilities. Also, in counties that do not have resource centers, CBRFs must refer certain prospective residents who are aged or have a physical or developmental disability to the county department responsible for administering long-term care

programs, and the county department must offer the prospective resident counseling concerning public and private long-term care benefit programs.

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

Under current law, intermediate care facilities for the mentally retarded (ICF-MRs) must pay the state an assessment of $4.45 per month for 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~~ annually to set the monthly per bed assessment amount at 5.5 percent of the 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 may reduce the assessment amount during any state fiscal year to avoid collecting an amount during that year that exceeds 5.5 percent of ICF-MR aggregate revenues.

29

Typed

***** ANALYSIS FROM -0332/11 *****

Under current law, DHFS annually assesses hospitals a statewide total of $1,500,000, in proportion to each hospital's respective gross private-pay patient revenues during the hospital's most recent fiscal year. Moneys from the assessments pay for a portion

move to p. 87

of MA program benefits, certain long-term care pilot projects under the Long-term Support Community Options Program (COP), and services under Family Care. The bill eliminates the current hospital assessment and, instead, authorizes DHFS to levy, enforce, and collect an annual assessment on hospitals, based on claims information collected by an entity from hospitals under the laws relating to health care information. Under the bill, the assessments are due before December 1 and are based on a rate not to exceed 1 percent of a hospital's gross revenues, as adjusted by DHFS. The assessments must be deposited into the health care quality fund, as created in the bill, and are first due before December 1, 2007.

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.

This bill reduces the statewide licensed nursing home bed cap to 42,000 beds and changes a 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, as determined by DHFS, or in an adjoining area.

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 *****

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~~ MA 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 *****

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 *****

Under current law, the long-term care ombudsman ~~or his or her designated representative~~ may enter, without notice, and have access to clients and residents of a nursing home, a CBRF, 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 (a long-term care facility). 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. Current law specifies rights of residents of nursing homes and CBRFs, 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. 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

38 Typed

~~aw, residential care apartment complexes are certified or 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.)

move to p. 96

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 ~~and 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 CBRFs. The bill authorizes ~~BOALTC~~ to employ staff within the classified service to provide advocacy

The bill provides that are same as

the Board on Aging and Long-Term Care

services to Family Care recipients or potential recipients, their families, and guardians.

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

OTHER HEALTH AND HUMAN SERVICES

Currently, DHFS ~~administers a grant program for statewide tobacco use control that funds programs~~ awards grants to prevent, reduce, or cease tobacco use. ~~Also under current law, a trust fund designated as~~ the permanent endowment fund ~~exists that~~ consists of the 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. The fund consists of moneys derived from the increase in ~~obtained by increasing~~ cigarette and other tobacco products taxes, ~~by transferring funds~~ moneys transferred from the permanent endowment fund, and moneys from certain other sources. Under the bill, moneys ~~from~~ in the health care quality fund are ~~appropriated in part for the statewide grant program for~~ used to fund, in part, the programs tobacco use control and for health care quality and patient safety information.

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

Under current law, DHFS may recover incorrect payments ~~that were~~ made for health care services under ~~the Medical Assistance~~ (MA) program that resulted from certain action or inaction by an applicant or recipient. If DHFS provides any medical assistance to a person as a result of, for example, an injury that was caused by a third

party, DHFS may recover from the third party the amount ~~of the medical assistance~~ STET provided. Also under current law, if an individual who is obligated to pay support (court-ordered child or family support or maintenance) has an overdue support obligation because of a failure to pay, his or her name, social security number, and amount of overdue support is posted on a statewide support lien docket.

This bill requires every insurer authorized to do business in this state, before paying ~~any~~ a claim of $500 or more, to verify with DHFS that the individual to whom the claim is to be paid does not have a medical assistance liability (an amount of medical assistance paid incorrectly under MA or that DHFS may recover from a third party) and to check the statewide support lien docket to ensure that the individual does not have ~~a support liability~~ an overdue support obligation. If the individual has ~~a~~ an overdue support ~~liability~~ obligation or a medical assistance liability, the insurer must pay the claim proceeds, up to the amount of the overdue obligation or liability, to DWD or DHFS before paying the individual any claim proceeds that remain.

This bill increases the fees that

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

~~Currently~~, the state registrar or a local registrar must charge ~~statutorily specified fees~~ a fee for issuing a ~~certified or uncertified~~ copy of a certificate of birth, death, divorce or annulment, or marriage (vital record), for verifying

information about the event without issuing a copy; for issuing any additional copy of the same vital record at the same time; for expedited service in issuing a vital record; and for searching vital records under certain circumstances. This bill increases all of these fees. Of the fees charged for certain birth certificates and copies, an amount must be forwarded to the secretary of administration for use by the Child Abuse and Neglect Prevention Board (CANPB) for expenses, for certain statewide projects, for the Family Resource Center Grant Program, and for technical assistance to organizations. The bill increases the amount that must be forwarded to the secretary of administration for deposit in program revenue appropriation accounts of CANPB.

The bill requires local registrars to forward to the secretary of administration, for credit to an 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, DHFS must distribute $1,000,000 in each fiscal year for domestic abuse services, $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, and $500,000 in each

fiscal year for comprehensive early childhood initiatives in Dane County for low-income families.

Currently, the state registrar must charge statutorily specified fees 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; making court-ordered name changes; for registering certain new or corrected vital records, and late registration of birth certificates. The bill increases these fee amounts.

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

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, WHEFA provides financial assistance to health facilities and participating health institutions. This bill prohibits WHEFA from providing such financial assistance unless the entity seeking assistance demonstrates progress in improving medical information systems technology to the secretary of

~~health and family services, who must consider advice of the health care quality and patient safety council.~~

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

Under current law, a person who is obligated to pay child or family support ~~(payer)~~ 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 (payee)~~. This bill ~~increases that annual receipt and disbursement fee to $65~~ and requires DWD to ~~collect an annual fee of $25 from a payee in addition to the fee paid by the payor~~.

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

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 -0878/5 *****

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 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 *****

Currently, DHFS ~~administers the "group home revolving loan fund," under which limited two-year~~ loans ~~are made~~ 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 -1272/5 *****

INSURANCE

This bill creates the Healthy Wisconsin Authority (HWA), which 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, and 13 other members who will serve four-year terms. HWA is treated like a state agency with respect to the open records and open meetings laws; the law regulating lobbying; state purchasing

requirements; exemption from income tax, sales and use tax, and property taxes; the Code of Ethics for Public Officials and Employees; all purposes under the Wisconsin Retirement System; and auditing by the Legislative Audit Bureau. HWA is unlike a state agency in that it may approve its own budget ~~without going through the state budgetary process~~; 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 it is not subject to statutory rule-making procedures. ~~Unlike most authorities under current law,~~ HWA may not issue bonds.

The bill directs HWA ~~must~~ to study options and develop recommendations for ~~implementing a reinsurance program to provide~~ providing reinsurance to groups and individuals ~~in the state~~ for catastrophic claims under health insurance policies ~~and must submit a report to the secretary of administration with its recommendations~~. HWA must develop and administer any reinsurance program for which legislation is enacted that authorizes or requires HWA to do so and may explore other ways to lower health care costs, including considering options for comprehensive health care reform.

***** ANALYSIS FROM -1561/1 *****

Under current law, a group health insurance policy that covers ~~provides coverage of~~ any inpatient hospital ~~services~~ treatment must cover ~~those services for the treatment~~ of at least 30 days or generally $7,000 of inpatient hospital treatment.

nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the expenses of 30 days of inpatient services or, generally, $7,000, whichever is less. 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, generally, $2,000. 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, generally, $3,000. 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, generally, $7,000 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. 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 *****

Excluding limited-scope benefit plans, medicare replacement or supplement policies, long-term care policies, and policies covering only certain specified

diseases, 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 up to four hours per month of 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 may be subject to any limitations or exclusions or cost-sharing provisions that apply generally under the policy or plan.

***** ANALYSIS FROM -1457/3 *****

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 independent evaluation. If 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 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.

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

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

84A

Covered

not under the Health Insurance Risk-Sharing Plan (HIRSP), which is the health insurance program that provides major medical health insurance coverage for disabled persons ~~with coverage~~ under Medicare, persons with HIV, and other persons who have been refused coverage in the private health insurance market. The pilot program is limited 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 be eligible for the health insurance premium subsidy program.