HEALTH AND FAMILY SERVICES AND INSURANCE

BOARD ON AGING AND LONG-TERM CARE

1. VOLUNTEER OMBUDSMAN PROGRAM

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $173,400 ($137,800 GPR and $35,600 PR) in 2007-08 and $212,500 ($170,000 GPR and $42,500 PR) in 2008-09 and 4.0 positions (3.20 GPR positions and 0.80 PR positions), beginning in 2007-08, to recruit, train, and supervise volunteers as part of an expansion of the Board's ombudsman program.

	Change to JFC Funding	Positions
GPR	- $307,800	- 3.20
PR	- 78,100	- 0.80
Total	- $385,900	- 4.00

2. OMBUDSMAN SERVICES FOR FAMILY CARE ENROLLEES

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $41,200 ($20,600 GPR and $20,600 PR) in 2007-08 and $51,100 ($25,600 GPR and $25,500 PR) in 2008-09 to fund 1.0 additional ombudsman position (0.50 GPR position and 0.50 PR position), beginning in 2007-08, to provide information and advocacy services to individuals over the age of 60 that are enrolled in the Family Care program.

	Change to JFC Funding	Positions
GPR	- $46,200	- 0.50
PR	- 46,100	- 0.50
Total	- $92,300	- 1.00

CHILD ABUSE AND NEGLECT PREVENTION BOARD

1. STATE PLAN FOR THE PREVENTION OF CHILD MALTREATMENT

Senate: No change to Joint Finance.

	Change to JFC Funding	Positions
GPR	- $1,440,100	- 1.00
SEG	140,600	1.00
Total	- $1,229,500	0.00

Assembly: Delete the provision that would provide $580,100 ($650,400 GPR and -$70,300 SEG) in 2007-08 and $719,400 ($789,700 GPR and -$70,300 SEG) in 2008-09 and convert 1.0 SEG position to 1.0 GPR position, beginning in 2007-08, to increase funding for activities relating to the state plan for the prevention of child maltreatment, including: (a) hiring a consumer education director; (b) addressing shaken baby syndrome by creating prevention materials for new parents and providing training for child care providers; (c) implementing a child sexual abuse prevention campaign; and (d) providing additional grants to organizations.

2. ATTACH TO DEPARTMENT OF CHILDREN AND FAMILIES

Senate: No change to Joint Finance.

Assembly: Delete the provision that would attach the CANP Board to the new Department of Children and Families (DCF), to reflect the deletion of all of the provisions in the bill that would create DCF.

DEPARTMENT OF CHILDREN AND FAMILIES

1. DEPARTMENT OF CHILDREN AND FAMILIES AND TRANSFERS FROM DHFS AND DWD TO THE NEW DEPARTMENT

Senate: No change to Joint Finance.

Assembly: Delete provisions that would: (a) create the Department of Children and Families (DCF); and (b) transfer funding and positions from DHFS and the Department of Workforce Development (DWD) to DCF, beginning in 2008-09.

HEALTH AND FAMILY SERVICES

Health Care Quality Fund (HCQF)

1. HEALTH CARE QUALITY FUND

Senate: No change to Joint Finance.

Assembly: Delete all provisions relating to the creation of the health care quality fund (HCQF), including the revenue sources to the fund and budgeted expenditures from the fund. The fiscal effect of these changes is summarized under separate items. The provisions relating to cigarette and tobacco taxes are summarized under "General Fund Taxes."

2. INJURED PATIENTS AND FAMILIES COMPENSATION FUND TRANSFER

Senate: No change to Joint Finance.

Assembly: Delete the provision that would transfer $175,000,000 from the injured patients and families compensation fund to the HCQF in 2007-08.

3. PERMANENT ENDOWMENT FUND TRANSFER

Senate: No change to Joint Finance.

Assembly: Delete the provision that would transfer $50,000,000 in each year from the permanent endowment fund to the HCQF. Instead, transfer $50,000,000 annually from the permanent endowment fund to the MA trust fund. Reduce MA benefits funding by $50,000,000 GPR annually and increase SEG funding from the MA trust fund by $50,0000,000 annually.

	Chg. to JFC
GPR	- $100,000,000
SEG	100,000,000
Total	$0

The permanent endowment fund consists of all the proceeds from the sale of the state's right to receive payments under a tobacco settlement agreement, and investment earnings on the proceeds.

4. REPLACE BASE GPR MA BENEFITS FUNDING

Senate: No change to Joint Finance.

Assembly: Delete provisions that would replace base GPR funding for medical assistance (MA) benefits with revenue from the HCQF. Increase funding in the bill by $362,900,000 GPR in 2007-08 and by $370,902,800 GPR in 2008-09 and reduce SEG funding by corresponding amounts.

	Chg. to JFC
GPR	$733,802,800
SEG	- 733,802,800
Total	$0

Delete provisions that would create four SEG appropriations from the HCQF to support: (a) MA and BadgerCare benefits; (b) MA contracts; (c) SeniorCare benefits; and (d) administration of the SeniorCare program.

5. HOSPITAL ASSESSMENT AND MA RATE INCREASE

Senate: No change to Joint Finance.

Assembly: Delete all provisions relating to the assessment on hospitals' gross revenues and MA rate increases for inpatient and outpatient hospital services.

	Chg. to JFC
SEG-REV	- $418,259,300
GPR	$119,659,900
FED	- 406,125,000
PR	3,000,000
SEG	- 418,259,300
Total	- $701,724,400

Reduce MA benefits by $344,467,500 ($57,909,700 GPR, -$198,344,400 FED, $1,500,000 PR, and -$205,532,800 SEG) in 2007-08 and $357,256,900 ($61,750,200 GPR, -$207,780,600 FED, $1,500,000 PR, and -$212,726,500 SEG) in 2008-09 to reflect the net fiscal effect of deleting provisions that would: (a) create an assessment on the gross revenues of hospitals; (b) deposit all revenue from the HCQF to increase MA rates for hospital services; and (c) to replace base GPR funding for MA benefits with SEG revenues from the HCQF.

6. DEMONSTRATION PROJECT TO PROVIDE MA COVERAGE TO LOW-INCOME, CHILDLESS ADULTS

Senate: Provide an additional $1,120,300 SEG from the HCQF and reduce funding by $343,500 FED in 2008-09 to reflect the administration's revised estimates of the cost of the proposal to expand primary and preventive health care services to adults under age 65 who have family incomes up to 200% of the federal poverty level (in 2007, $25,540 for a single adult), and who are not otherwise eligible for MA, BadgerCare, or Medicare, and who did not have coverage under the health insurance risk-sharing plan within six months before applying to participate in the project.

	Chg. to JFC
SEG	$1,120,300
FED	- 343,500
Total	$776,800

Assembly: Delete all provisions relating to a demonstration project to provide MA coverage to childless adults. Increase GPR funding by $3,150,000 GPR in 2007-08 and decrease funding by $22,418,500 (-$2,944,000 GPR, -$13,320,800 FED, and -$6,153,700 SEG from the HCQF) in 2008-09 and delete 6.0 positions (-3.0 FED positions and -3.0 SEG positions), beginning in 2008-09, to reflect the net effect of deleting the expansion of MA to childless adults under a demonstration project.

	Change to JFC Funding	Positions
GPR	$206,000	0.00
FED	- 13,320,800	- 3.00
SEG	- 6,153,700	- 3.00
Total	- $19,268,500	- 6.00

7. TOBACCO USE CONTROL GRANTS

Senate: Increase funding for tobacco use control grants by $10,162,500 SEG in 2007-08 and by $10,137,500 SEG in 2008-09 from the HCQF. The Joint Committee on Finance provided $19,837,500 SEG in 2007-08 and $19,862,500 SEG in 2008-09 from the HCQF for this purpose. Consequently, a total of $30,000,000 SEG annually would be budgeted from the HCQF for tobacco use control grants.

	Chg. to JFC
SEG	$20,300,000

Assembly: Reduce funding for tobacco use control grants by ~~$17,337,500~~ (-$19,837,500 SEG and $2,500,000 GPR) in 2007-08, and by $17,362,500 (-$19,862,500 SEG and $2,500,000 GPR) in 2008-09. This item would delete all SEG funding from the HCQF for grants, and provide a total of $2,500,000 GPR annually for grants. Base funding for grants is $10,000,000 GPR annually.

	Chg. to JFC
GPR	$5,000,000
SEG	- 39,700,000
Total	- $34,700,000

8. GRANT TO SUPPORT COLPOSCOPY PROGRAM AND ONGOING COSTS FOR SERVING MA RECIPIENTS

Senate: Modify the JFC provision that would provide $100,000 SEG in 2007-08 and $75,000 SEG in 2008-09 from the HCQF for DHFS to distribute to an entity to provide colposcopic examinations and fund ongoing operational costs for services provided to individuals enrolled in, or eligible for, medical assistance so that this item would be funded from GPR, rather than SEG revenues.

	Chg. to JFC
GPR	$175,000
SEG	- 175,000
Total	$0

Under the JFC provision, DHFS would be required to distribute this funding to an entity that meets the following criteria: (a) the entity is located in the western or northern Wisconsin public health region of the state as determined by DHFS; and (b) the entity provides Papanikolaou tests (Pap smears) to a patient population, of which at least 50% are enrolled in, or eligible for, medical assistance. These criteria would not be modified.

Assembly: Modify the Joint Finance provision by: (a) deleting all SEG funding from the HCQF; and (b) instead providing $37,500 GPR annually for this purpose.

	Chg. to JFC
GPR	$75,000
SEG	- 175,000
Total	- $100,000

9. WISCONSIN WELL -WOMAN PROGRAM

Senate: Modify the provision that would provide $62,500 SEG annually from the HCQF to provide additional breast cancer and cervical cancer screenings under the Wisconsin well-woman program so that this item would be funded from GPR, rather than SEG revenues.

	Chg. to JFC
GPR	$125,000
SEG	- 125,000
Total	$0

Assembly: Modify the Joint Finance provision by: (a) deleting all SEG funding from the HCQF; and (b) instead providing $37,500 GPR annually for this purpose.

	Chg. to JFC
GPR	$75,000
SEG	- 125,000
Total	- $50,000

Medical Assistance -- Long-Term Care

1. FAMILY CARE EXPANSION

Senate: No change to Joint Finance.

Assembly: Delete statutory and funding changes relating to the expansion of Family Care. Reduce funding by $18,284,100 (-$930,000 GPR, -$6,938,900 FED and -$10,415,200 PR) in 2007-08 and by $62,319,400 (-$19,145,700 GPR, -$13,693,600 FED and -$29,480,100 PR) in 2008-09.

	Chg. to JFC
GPR	- $5,208,200
FED	- 16,035,000
PR	- 39,895,300
Total	- $61,138,500

Instead, provide $9,609,500 ($7,339,800 GPR and $2,269,700 FED) in 2007-08 and $9,855,500 ($7,527,700 GPR and $2,327,800 FED) in 2008-09 to fully fund aging and disability resource centers (ADRCs) established during the 2005-07 biennium without sufficient ongoing base funding. No additional funding for the expansion of the Family Care program would be provided.

Retain the provisions that would: (a) replace the current titles of definitions of functional eligibility for the Family Care benefit with "nursing home level of care," rather than "comprehensive," and "non-nursing home level of care," rather than "intermediate;" and definitions clarifying when an individual has met each level of functional eligibility; and (b) eliminate the current law requirement that DHFS extend entitlement for the Family Care benefit to people who are not eligible for MA by January 1, 2008. However, permit individuals who are not eligible for MA, but who are currently receiving services under the Family Care benefit

upon the passage of the bill, to continue to be eligible for, but not entitled to, the Family Care benefit. Provide that an individual must be eligible for MA in order to be entitled to the Family Care benefit. Retain the provision that would require DHFS to contract for ombudsman services for Family Care enrollees who are developmentally disabled, and the provision that would require case management organizations to contract with any willing provider.

2. FAMILY CARE -- FUNCTIONAL ELIGIBILITY DEFINITIONS

Senate/Assembly: Specify that the provisions that would replace the current titles of definitions of functional eligibility for the Family Care benefit with "nursing home level of care" rather than "comprehensive" and "non-nursing home level of care" rather than "intermediate" be made effective January 1, 2008, rather than on the effective date of the bill.

3. FAMILY CARE – LIAISON AND ADVOCACY SERVICES FOR GRANT COUNTY

Senate: Direct DHFS to provide $75,000 GPR annually, from funding budgeted for Family Care aging and disability resource centers, to Grant County to provide, with respect to issues concerning Family Care benefits, liaison services between the county and a managed care organization and advocacy services on behalf of the county.

Assembly: No change to Joint Finance.

4. NURSING HOME RATES AND BED ASSESSMENT INCREASE

	Chg. to JFC
SEG-REV	$1,607,600
GPR	-$591,500
FED	17,521,300
PR	787,200
SEG	12,806,600
Total	$30,523,600

Senate: Provide $9,753,900 (-$142,400 GPR, $5,698,300 FED, and ~~$4,198,000~~ SEG) in 2007-08 and $19,982,500 (-$449,100 GPR, $11,823,000 FED, and $8,608,600 SEG) in 2008-09 to reflect reestimates of the fiscal effect of the provisions to fund nursing home rate increases by increasing the nursing home bed assessment, and to delay the effective date of the bed assessment increase until January 1, 2008. In addition, increase estimates of revenue to the MA trust fund by $152,400 in 2007-08 and by $1,455,200 in 2008-09. Increase funding for the Wisconsin Veterans Home at King and the Veterans Home at Union Grove by $262,400 PR in 2007-08 and by $524,800 PR in 2008-09 to reflect increased costs to those facilities due to the increase in the bed assessment.

These funding modifications reflect reestimates of: (a) the projected number of licensed nursing home beds; (b) the costs of paying back nursing homes to offset the additional costs they would incur to pay the increased assessments; (c) the annual rate increase percentage that could be supported given the reestimate of bed assessment revenues; (d) total funding that would be needed to support reimbursements to nursing homes under the MA base reestimate item; and (e) the federal financial participation rates.

Assembly: Delete the Joint Finance provisions that would increase the assessment on licensed nursing home beds from $75 to up to $127 per month. Decrease estimates of anticipated revenues to the segregated MA trust fund by $11,716,100 in 2007-08 and by $21,921,300 in 2008-09.

	Chg. to JFC
GPR-REV	- $27,600,000
SEG-REV	- 6,037,400
GPR	- $11,331,200
FED	- 7,604,900
SEG	5,753,100
Total	- $13,183,000

Delete $17,746,500 (-$10,218,400 FED and -$7,528,100 SEG) in 2007-08 and $34,222,500 (-$19,903,700 FED and -$14,318,800 SEG) in 2008-09 that would be provided to: (a) increase MA rates paid to nursing homes by 2% in 2007-08 and by another 2% in 2008-09; and (b) reimburse facilities, through higher MA payments, for their costs in paying the increased assessments.

Instead, provide $38,786,000 ($16,268,800 GPR and $22,517,200 FED) in 2008-09 to increase MA nursing home rates by approximately 5% in 2008-09.

Further, modify current law to specify that all revenue from the nursing home bed assessment would be deposited to the MA trust fund, beginning in 2007-08. Under current law, all revenue that exceeds $13.8 million in each year is deposited to the MA trust fund and $13.8 million from assessment revenue is deposited to the general fund. Reduce MA benefits funding by $13.8 million GPR annually and increase MA benefits funding by $13.8 million SEG annually, and reduce estimates of general fund revenues by $13.8 million GPR annually, and increase estimates of revenues deposited to the MA trust fund by $13.8 million annually.

5. NURSING HOME PAYMENT METHODOLOGY -- DESIGNATE ROCK COUNTY'S LABOR REGION

Senate: Require DHFS to include Rock County in a labor region that currently includes Dane, Iowa, Columbia, and Sauk County for the purpose of determining standards for payment of allowable direct care costs to nursing homes under the MA program. Provide $777,900 ($330,000 GPR and $447,900 FED) in 2007-08 and $786,700 ($330,000 GPR and $456,700 FED) in 2008-09 to hold nursing homes in Dane, Iowa, Columbia, and Sauk County harmless in the determination of reimbursement related to labor region adjustments.

	Chg. to JFC
GPR	$660,000
FED	904,600
Total	$1,564,600

Under current law, DHFS is required to establish standards for payment of allowable direct care costs that are based on direct care costs for all nursing homes, as adjusted to reflect regional labor cost variations. The statutes currently require DHFS to treat Dane, Iowa, Columbia, and Sauk County as a single labor region.

Assembly: No change to Joint Finance.

6. MANAGED CARE PILOT PROGRAMS FOR CHILDREN'S LONG-TERM CARE

Senate: No change to Joint Finance.

Assembly: Delete provisions that would: (a) provide $250,000 annually for DHFS to provide grants to organizations or groups of organizations for technical assistance and planning services in support of family-centered managed care for children with long-term support needs; and (b) direct DHFS to seek waivers of federal MA statutes and regulations from the U.S. Department of Health and Family Services to implement, in at least three pilot sites, a managed care program for the long-term care of children with disabilities.

	Chg. to JFC
GPR	- $500,000

7. FEDERAL MA ADMINISTRATION FUNDS FOR THE BOARD ON AGING AND LONG-TERM CARE

Senate: No change to Joint Finance.

Assembly: Delete $124,000 in 2007-08 and $135,800 in 2008-09 in federal MA (administration) matching funds to reflect that two items for the Board on Aging and Long-Term Care would be deleted: (a) an expansion of the Board's volunteer ombudsman program; and (b) increased ombudsman services in conjunction with the expansion of Family Care. Since the Assembly deleted these items, there would be no state funds expended to generate these federal matching funds.

	Chg. to JFC
FED	- $259,800

8. COMMUNITY RELOCATION INITIATIVE – AUTHORITY TO PROVIDE SERVICES TO ADDITIONAL CLIENTS

Senate: Delete the current law provision that requires DHFS to submit a request to the Joint Committee on Finance under a 14-day passive review process to provide services to more than 150 individuals under the nursing home diversion initiative. Instead, require DHFS to seek approval from the Secretary of the Department of Administration to expand the number of individuals served under the program.

2005 Wisconsin Act 355 authorized DHFS to pay an enhanced reimbursement rate to counties for services provided under the community integration program (CIP II) to up to 150 individuals who meet the medical assistance (MA) level of care requirements for nursing home care, but who are diverted from imminent entry into nursing homes on or after July 27, 2005. The act also authorized DHFS to submit a request to the Joint Committee on Finance under a passive review process to increase the number of persons served by the diversion initiative above the 150 person limit, should it become likely that the number of individuals eligible to benefit from this provision may exceed the statutory limit of 150.

Assembly: No change to Joint Finance.

9. STATE LONG-TERM CARE PARTNERSHIPS -- TRAINING REQUIREMENTS FOR INDIVIDUALS WHO SELL LONG-TERM CARE INSURANCE POLICIES

Senate/Assembly: Modify the provision that would direct the Office of the Commissioner of Insurance (OCI) to develop training requirements for individuals who sell long-term care insurance policies to instead require OCI to approve training requirements.

The JFC provision would require DHFS to submit an amendment to the state MA plan that establishes a long-term care partnership program, and would direct DHFS to implement the program if the amendment were approved. Under the program, DHFS would exclude an amount equal to the amount of benefits that an individual receives under a qualifying long-term care insurance policy, when determining: (a) the individual's resources for purposes of determining the individual's eligibility for MA; and (b) the amount to be recovered from the individual's estate if the individual received MA.

The JFC provision requires DHFS and OCI to develop a training program for individuals who sell long-term care insurance policies to ensure that those individuals understand the relation of long-term care insurance to the MA program and are able to explain to consumers the protections offered by long-term care insurance and how this type of insurance relates to private and public financing of long-term care. The JFC provision specifies requirements for this training program, and prohibits a person from soliciting, negotiating, or selling long-term care insurance unless the person is a licensed intermediary and he or she completes the initial training program by January 1, 2009, and completes the ongoing training every 24 months after completing the initial training.

Medical Assistance -- General

1. BADGERCARE PLUS AND RELATED INITIATIVES

Senate: No change to Joint Finance.

Assembly: Delete all funding and statutory changes relating to BadgerCare Plus, except the provision that would combine the MA and BadgerCare benefits appropriations. Reduce funding by $127,400 ($2,121,300 GPR, $2,512,100 FED and -$4,760,800 PR) in 2007-08 and by $31,463,100 (-$2,121,300 GPR, -$7,480,200 FED and -$21,861,600 PR) in 2008-09 to reflect this change.

	Chg. to JFC
GPR	- $22,984,800
FED	- 39,784,700
PR	- 26,622,400
Total	- $89,391,900

Instead, reduce MA and BadgerCare benefits and administration funding by $17,807,500 (-$7,183,600 GPR, and -$10,623,900 FED) in 2007-08 and by $39,993,900 (-$15,801,200 GPR and -$24,192,700 FED) in 2008-09 to reflect the administration's estimates of savings that would be realized by: (a) serving 80% of current fee-for-service enrollees in a managed care setting by the end of 2008-09; (b) applying the same nominal copayments that are currently required of recipients who are not enrolled in health maintenance organizations (HMOs) to recipients who are enrolled in HMOs; and (c) simplifying eligibility criteria for Family MA recipients.

2. BADGERCARE PLUS AND HEALTH CARE TAX CREDIT

Senate: No change to Joint Finance.

Assembly: Delete the provision that would repeal the current statutory requirement that the HIRSP Authority design and administer a health care tax credit (HCTC) program, under which a covered individual may receive a federal income tax credit for a portion of the premiums they pay for coverage.

In addition, delete the provisions that would: (a) require DHFS to seek any necessary federal approvals to ensure that BadgerCare Plus is a HCTC qualifying plan; (b) specify that, if BadgerCare Plus is determined to be a HCTC qualifying plan, expand eligibility to BadgerCare Plus to include any individual who would be eligible for the HCTC, and that these individuals would remain eligible for BadgerCare Plus as long as they are eligible for the HCTC; and (c) specify that all individuals eligible for the HCTC would be required to pay premiums equal to the capitation payments DHFS would make on behalf of similar individuals enrolled in BadgerCare Plus, or the full per member per month cost of coverage, whichever is appropriate.

3. NON-INSTITUTIONAL PROVIDER RATE INCREASE

Senate: No change to Joint Finance.

Assembly: Delete provisions that would increase reimbursement for certain non-institutional services provided to MA and BadgerCare recipients. Reduce MA benefits funding by $14,130,700 (-$5,814,200 GPR and -$8,316,500 FED) in 2007-08 and $44,063,700 (-$17,240,700 GPR and -$26,823,000 FED) in 2008-09 to reflect this change.

	Chg. to JFC
GPR	- $23,054,900
FED	- 35,139,500
Total	- $58,194,400

Joint Finance would fund rate increases for all noninstitutional provider services by 1% in 2007-08 and an additional 2% (for a total of 3%, compared to current rates) in 2008-09, except that: (a) federally-qualified health care centers and rural health care centers would receive no rate increase, since MA currently pays their costs of serving MA recipients; (b) the rate increase would not be applied to common carrier transportation allocations to counties; (c) Joint Finance would increase reimbursement to pharmacies that dispense drugs to MA and BadgerCare recipients by eliminating DHFS' current practice of subtracting $0.50 per drug claim from the

total reimbursement a pharmacy receives; and (d) rates for psychiatric services would be increased by 20%, beginning in 2007-08.

4. MA INPATIENT AND OUTPATIENT HOSPITAL RATE INCREASE

Senate: No change to Joint Finance.

Assembly: Provide $26,224,800 ($11,000,000 GPR and $15,224,800 FED) in 2008-09 to provide a rate increase to hospitals for services they provide to MA and BadgerCare recipients.

	Chg. to JFC
GPR	$11,000,000
FED	15,224,800
Total	$26,224,800

Of the amount provided, $19,072,600 ($8,000,000 GPR and $11,072,600 FED) is provided to fund rate increases for inpatient services, specific to a new supplemental category described below, and $7,152,200 ($3,000,000 GPR and $4,152,200 FED) to fund rate increases for outpatient services.

With respect to inpatient services, the intent is to direct DHFS to amend the MA state plan to include an additional category of disproportionate share hospital (DSH) payments. The DSH qualifying threshold of inpatient MA utilizations would be 18%, meaning that the percent of MA inpatient days that a hospital has in proportion to its total inpatient days would need to be at least 18% to qualify. In addition, there would be a cap of $7,500,000 all funds to any qualifying acute care hospital and the funds would need to be distributed based upon MA utilization. Any current supplemental payments would be maintained, but subtracted from the additional funds paid out to affected hospitals from this new DSH program. Finally, in determining all payments, DHFS would use a more current data source, which would be the most recently submitted unaudited cost report. The current DSH program would continue to utilize audited cost reports, as is current practice.

There are no statutory provisions relating to this proposal, other than to increase the GPR and MA and BadgerCare benefits appropriation by $11,000,000 in 2008-09.

5. DENTAL RATE INCREASE PILOT PROJECT

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $4,112,800 ($1,750,000 GPR and $2,362,800 FED) in 2007-08 and $4,172,600 ($1,750,000 GPR and $2,422,600 FED) in 2008-09 to increase MA pediatric dental rates in Brown, Racine, and La Crosse Counties, beginning in 2007-08, under a pilot project.

	Chg. to JFC
GPR	- $3,500,000
FED	- 4,785,400
Total	- $8,285,400

Under Joint Finance, DHFS would be directed to seek any necessary approval from the U.S. Secretary of Health and Human Services to implement the project, and, if the Secretary provides the approval, or if no such approval is required, DHFS would be required to

implement the rate increase for the remainder of the 2007-09 biennium. If DHFS implements the rate increase, DHFS would be required to report on the effect of this pilot project to the Joint Committee on Finance and the appropriate standing committees of the Legislature by no later than January 1, 2009, on the effect the rate increase had on dental access to MA and BadgerCare recipients. DHFS would be permitted to use total funding under this item ($8,285,400 all funds) in either or both years of the biennium.

6. MA DENTAL RATE INCREASE

Senate: No change to Joint Finance.

Assembly: Provide $7,152,200 ($3,000,000 GPR and $4,152,200 FED) in 2008-09 to increase MA reimbursement to dentists for services they provide to MA and BadgerCare recipients.

	Chg. to JFC
GPR	$3,000,000
FED	4,152,200
Total	$7,152,200

7. CLAIM COMMON CARRIER TRANSPORTATION AS AN MA SERVICE AND ESTABLISH TRANSPORTATION BROKER PROGRAM

Senate: No change to Joint Finance.

Assembly: Modify Joint Finance to require DHFS to contract with a transportation manager (broker) that would provide a single point of contact for MA and BadgerCare recipients who require non-emergency transportation services (specialized medical vehicle and common carrier transportation services) to receive medical services. Provide $52,400 ($26,200 GPR and $26,200 FED) in both years for DHFS to contract for a program manager who would meet with stakeholders, issue a request-for-proposal, and negotiate the contract.

	Chg. to JFC
GPR	- $4,288,000
FED	- 5,416,800
Total	- $ 9,704,800

Reduce MA and BadgerCare benefits funding by $9,809,600 (-$4,340,400 GPR and -$5,469,200 FED) in 2008-09 to reflect projected savings of using a transportation broker to coordinate non-emergency transportation services. These projected savings are in addition to the savings that the administration projects will be realized by claiming common carrier transportation services as a MA benefit, rather than as an administrative cost, beginning in 2007-08.

8. PAY FOR CERTAIN MEDICARE PART B SERVICES WITH GPR

Senate: No change to Joint Finance.

Assembly: Modify Joint Finance to delete the provisions to fund benefits and implementation costs of requiring all MA recipients (including recipients that participate in MA home-and community-based waiver programs, Family Care, the MA purchase plan, the program for all-inclusive care for elderly (PACE) and MA demonstration programs) and BadgerCare recipients to enroll in Medicare Part B as a condition of receiving MA services, if they are eligible for Medicare Part B. Reduce funding in the bill by $4,438,300 (-$1,924,500 GPR and -$2,513,800 FED) in 2007-08 and by $7,876,500 (-$3,348,900 GPR and -$4,527,600 FED) to reflect this change.

	Chg. to JFC
GPR	- $2,240,300
FED	- 9,574,500
Total	- $11,814,800

Instead, increase funding by $500,000 ($1,177,700 GPR and -$677,700 FED) in 2007-08 and by $0 ($1,855,400 GPR and -$1,855,400 FED) in 2008-09 to: (a) fund MA payments for services for MA recipients that are eligible for Medicare Part B, but who are not enrolled in the program with GPR funds only, effective January 1, 2008 ($927,700 GPR and -$927,700 FED in 2007-08 and $1,855,400 GPR and -$1,855,400 FED in 2008-09); and (b) provide funding to modify DHFS computer systems to implement this proposal ($250,000 GPR and $250,000 FED in 2007-08).

This provision responds to a change in federal policy that no longer permits states to claim federal MA matching funds for state costs that could have been paid by Medicare Part B if the recipient was enrolled in Medicare Part B.

9. FAMILY PLANNING DEMONSTRATION PROJECT

Senate: No change to Joint Finance.

Assembly: Delete the provisions that would: (a) provide family planning services to men between the ages of 15 and 44, in addition to women in that age range (as provided in current law); and (b) increase, from 185% to 200% of the federal poverty level, the maximum family income a man or woman may have as a condition of participating in the program. Increase funding for MA benefits by $711,200 ($375,400 GPR and $335,800 FED) in 2008-09 to reflect this change.

	Chg. to JFC
GPR	$375,400
FED	335,800
Total	$711,200

In addition, increase from 15 years to 18 years, the minimum age a woman must be to enroll in the program.

10. CEMETERY, FUNERAL, AND BURIAL AIDS

Senate: No change to Joint Finance.

Assembly: Modify current law relating to county and tribal reimbursement for funeral and burial expenses of indigent individuals so that a county or tribe would provide no

reimbursement in cases where the total funeral and burial expenses exceed $4,500, rather than $3,500, as provided under current law.

This provision would not modify the current law provisions that limit county and tribal reimbursement to: (a) the lesser of $1,000 or the cemetery expenses that are not paid by the estate of the deceased and other persons; and (b) the lesser of $1,500 or the funeral and burial expenses not paid by the estate of the deceased and other persons.

DHFS is required to reimburse counties and tribes for funeral and burial expenses for deceased individuals who, at the time they died, were receiving W-2, supplemental security income (SSI) benefits, or MA benefits, and whose estates are insufficient to pay these expenses.

11. TIME LIMITS FOR PAYING MA, BADGERCARE, SENIORCARE AND FAMILY CARE CLAIMS

Senate: No change to Joint Finance.

Assembly: Require DHFS to issue payment for at least 95% of proper provider claims for reimbursement under the MA, BadgerCare, and SeniorCare program within 30 days of receipt of the claims and issue payment for 100% of such claims within 45 days of receipt of the claims. However, provide that DHFS could exceed these claims payment deadlines under any of the following circumstances: (a) if a claim is filed under Medicare, DHFS would have up to six months after DHFS or the provider receives notice of the disposition of the Medicare claim to issue payment for the service; (b) DHFS could issue payments at any time in accordance with a court order or to comply with a hearing decision or a corrective action taken by DHFS; and (c) if DHFS is granted a waiver that exempts DHFS from federal deadlines for payment of claims, DHFS could exceed the deadlines to the extent permitted in the waiver.

In addition, require care management organizations (CMOs) that pay health care providers for services they provide to Family Care enrollees to issue payment for 95% of proper claims for reimbursement for Family Care benefit services within 30 days of receipt of the claims and pay 100% of such claims within 45 days of receipt of the claims. Specify that this provision would first apply to CMOs that enter into or renew a contract with DHFS to serve as a care management organization on the bill's general effective date.

12. HMO RATE INCREASE -- PASS-THROUGH TO HEALTH PROVIDERS

Senate: Modify current law requirements relating to the delivery of MA services through health maintenance organizations (HMOs) as follows.

First, require DHFS to calculate that portion of any increase in the capitation rate paid to each HMO if the increase is made to reflect increases in fee-for-service MA payment rates to one or more classes of providers. Second, require each HMO to increase its payments to any class of

providers for services to MA recipients in amounts that DHFS determines are consistent with both the purpose and intent of the fee-for-service rate increase and the objective of reducing unnecessary utilization through managed care, and to amend its contracts with service providers correspondingly. Third, require DHFS to conduct audits to ensure that HMOs comply with these provisions. Provide that the changes would first apply to contracts in existence on the effective date of the bill.

Assembly: No change to Joint Finance.

Health

1. VITAL RECORDS AUTOMATION PROJECT AND VITAL RECORDS FEES

Senate: No change to Joint Finance.

Assembly: Delete the JFC provision that would provide $3,452,600 GPR in 2007-08 and $4,547,400 GPR in 2008-09 for the automation of the state's vital records system. Joint Finance would provide the GPR funding for the vital records automation project in Joint Committee on Finance program supplemental appropriation.

	Chg. to JFC
PR-REV	$6,927,800
GPR	- $8,000,000

Instead, increase vital records fees as follows: (a) increase the fee for one certified copy or one uncertified copy of a birth certificate from $12 to $20; (b) increase the fee for one certified copy or one uncertified copy of a death, marriage, or divorce record from $7 to $20; and (c) increase the fee for expedited services from $10 to $20. Require the state registrar and any local registrar to forward to the DOA Secretary the full amount of the increase in these fees for deposit in the DHFS vital records program revenue appropriation. Increase estimated program revenue by $2,958,500 in 2007-08 and $3,969,300 in 2008-09. Specify that these fee increases would sunset on July 1, 2010. This item would not increase DHFS' PR appropriation to expend additional revenue from the proposed fee increases. However, DHFS could seek authority under s. 16.515 of the statutes to expend these revenues for the vital records automation project.

2. GRANTS FOR COMMUNITY HEALTH CENTERS

Senate: No change to Joint Finance.

Assembly: Delete the provision that would increase funding to support community health centers by $3,000,000, beginning in 2008-09. Base funding for these grants is $3,000,000 GPR annually.

	Chg. to JFC
GPR	- $3,000,000

3. GRANTS FOR COMMUNITY HEALTH CENTERS -- HEALTHNET OF JANESVILLE, INC.

Senate: Provide $25,000 annually to HealthNet of Janesville, Inc. to provide health care services to uninsured and low-income residents of Rock County. HealthNet of Janesville, Inc. is a free clinic that serves uninsured individuals with household incomes at or below 185% of the federal poverty level. Under current law, DHFS provides $25,000 annually to support HealthNet of Janesville, Inc.

	Chg. to JFC
GPR	$50,000

Assembly: No change to Joint Finance.

4. DENTAL HEALTH -- COMMUNITY CONNECTIONS FREE CLINIC IN DODGEVILLE

Senate: Provide $17,500 in 2007-08 and $17,500 in 2008-09 in one-time funding to the Community Connections Free Clinic in Dodgeville to provide dental services to low-income residents of Iowa County and surrounding areas.

	Chg. to JFC
GPR	$35,000

Assembly: No change to Joint Finance.

5. POISON CONTROL PROGRAM

Senate: Increase funding for the statewide poison control program by $50,000 annually to increase funding for public education activities. DHFS has implemented a statewide poison control system that provides poison control services available statewide on a 24-hour per day and 365-day per year basis, and that provides poison information and education to health care professionals and the public. Funding for the program is used to support the activities of the Wisconsin Poison Center, which is also supported by Children's Hospital of Wisconsin. Base GPR funding for the statewide poison control program is $375,000.

	Chg. to JFC
GPR	$100,000

Assembly: No change to Joint Finance.

6. HIV/AIDS PROGRAMS -- HIRSP PILOT PROGRAM

Senate: No change to Joint Finance.

Assembly: Reduce funding for the state's HIV/AIDS program by $400,000 in 2007-08, and by $876,600 in 2008-09 to reflect: (a) reducing funding for the Mike Johnson life care and early intervention grants, by $400,000 in 2007-08 and by $1,000,000 in 2008-09; and (b) beginning the HIRSP pilot project on January 1, 2008, rather than October 1, 2007.

	Chg. to JFC
GPR	- $1,276,600

Delete statutory changes that would increase the amounts DHFS can award in Mike Johnson life care and early intervention grants.

7. HIV/AIDS PROGRAMS -- BLACK HEALTH COALITION OF WISCONSIN, INC.

Senate: Require DHFS to provide $100,000 FED in 2007-08 as a one-time grant to the Black Health Coalition of Wisconsin, Inc. to provide HIV infection outreach, education referral, and other services. The source of the federal funds is funding the state receives under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 Part B grant funds.

Assembly: No change to Joint Finance.

8. INFANT MORTALITY PROJECT

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide one-time funding of $250,000 in 2007-08 and $250,000 in 2008-09 for an infant mortality project in Racine County.

	Chg. to JFC
GPR	- $500,000

The JFC provision would require DHFS to provide one-time funding of $250,000 GPR in 2007-08 and 2008-09 for DHFS to distribute to the city health department (Racine) in a county with a population of at least 190,000 but less than 230,000 to provide a program of services to reduce fetal and infant mortality under which the city health department shall directly or indirectly do all of the following in or behalf of areas of the county that are encompassed by the zip codes 53402 to 53406 and that are at risk for high fetal and infant mortality and morbidity, as determined by DHFS:

a. Collaborate with faculty in the health disciplines of an academic institution and with a hospital that serves significant populations at high risk for poor birth outcomes, including low birth weights, prematurity, and gestational diabetes, to identify and implement best practices and evidenced-based practices to reduce fetal and infant mortality and morbidity;

b. Identify necessary pre-conception, prenatal, and postnatal services and assess the availability of these services for women in the areas who lack insurance coverage or who are Medicaid or BadgerCare recipients;

c. Develop and implement models of care for all women in the areas who meet risk criteria, as specified by the department, and provide comprehensive prenatal and postnatal care coordination and other services, including home visits by registered nurses who are public health nurses or who meet the qualifications of public health nurses, as specified in statute, or social workers, as defined in statute;

d. Conduct social marketing, including outreach assuring health care access, public

awareness programs, community health education programs, and other best practices and evidence-based practices, to reduce fetal and infant mortality and morbidity;

e. Evaluate the quality and effectiveness of the services provided under paragraphs c. and d., above, and

f. Annually prepare a report on fetal and infant mortality and morbidity in areas of the county that are encompassed by the zip codes 53402 to 53406, which shall be derived, in part, from a multi-disciplinary review of all fetal and infant deaths in the relevant year and shall specify causation found for the mortality or morbidity. Require the city health department to submit the report to all of the following: (1) the City of Racine; (2) DHFS; (3) the Legislature in the manner provided by statute; and (4) the Governor.

9. FAMILY PLANNING SERVICES

Senate: No change to Joint Finance.

Assembly: Modify provisions relating to the state's family planning program under s. 253.07 of the statutes as follows.

Definition of Family Planning. Modify the statutory definition of "family planning" to delete the current provision that includes providing nondirective information explaining pregnancy termination. Currently, "family planning" means voluntary action by individuals to prevent or aid conception, but does not include the performance, promotion, encouragement or counseling in favor of, or referral either directly or through an intermediary for, voluntary termination of pregnancy, but may include the providing of nondirective information explaining any of the following: (a) prenatal care and delivery; (2) infant care, foster care or adoption; or (3) pregnancy termination. This provision would delete reference to (3).

Eligibility for Funding. Authorize DHFS to provide funding for family planning services to any county or other governmental body, but prohibit DHFS from providing such funding to any county or other governmental body that provides counseling services with respect to the termination of pregnancies or that provides abortion services. Prohibit any county or other governmental body that receives such funding from contracting with any other county, governmental body, or private entity to provide family planning services if that other county, governmental body, or private entity provides counseling services with respect to the termination of pregnancies or provides abortion services. Further, prohibit DHFS from providing funding for family planning services to any private entity.

10. ABSTINENCE EDUCATION

Senate: No change to Joint Finance.

Assembly: Require DHFS to apply annually for federal abstinence education funds from the Title V State Abstinence Education Grant Program administered by the U.S. Department of Health and Human Services (DHHS), Administration on Children, Youth, and Families. Specify that if the DHHS Secretary grants an allotment to the state, DHFS must accept the allotment and use it in accordance with federal law, regulations and guidelines applicable to the allotment.

11. COPYING CHARGES FOR MEDICAL RECORDS

Senate: No change to Joint Finance.

Assembly: Modify current law to permit health care providers to charge a fee up to $1.00 per record page for copies of medical records, indexed for inflation for years beginning after 2007. Current DHFS rules permit providers to charge up to $0.31 per record page.

12. LIABILITY IMMUNITY FOR HEALTH CARE PROVIDERS

Senate: No change to Joint Finance.

Assembly: Specify that a health care provider, health care facility, or employee thereof, that reports in good faith or provides information, the disclosure of which is not expressly prohibited by state or federal law or rule, or participates in, or testifies in any action or proceeding, is immune from any civil or criminal liability that may result from any act or omission in reporting or providing information, in the following circumstances: (a) reports to any professionally recognized accrediting or standard-setting body that has accredited, certified, or otherwise approved the health care facility or health care provider, to any officer or director of the health care facility or health care provider, or to any employee thereof who is in a supervisory capacity or in a position to take corrective action, with respect to an allegation that a health care provider, health care facility, or employee thereof has violated any state or federal law, rule, or regulation, or that there exists any situation in which the quality of any health care service provided by the health care facility or health care provider or by any employee thereof violates any standard established by any state or federal law or regulation or any clinical or ethical standard established by a professionally accrediting or standard-setting body and poses a potential risk to public health or safety, has engaged in unprofessional conduct, or has acted negligently in treating a patient; (b) initiates, participates in, or testifies in any action or proceeding in which it is alleged that a health care provider, health care facility, or employee thereof has violated any state or federal law, rule, or regulation, or that there exists any situation in which the quality of any health care service provided by the health care facility or health care provider or by any employee thereof violates any standard established by any state or federal law or regulation or any clinical or ethical standard established by a professionally accrediting or standard-setting body and poses a potential risk to public health or safety, has engaged in unprofessional conduct, or has acted negligently in treating a patient; (c) provides to any legislator or legislative committee any information relating to an allegation that a health

care provider, health care facility, or an employee thereof has violated any state or federal law, rule, or regulation, or that there exists any situation in which the quality of any health care service provided by the health care facility or health care provider or by any employee thereof violates any standard established by any state or federal law or regulation or any clinical or ethical standard established by a professionally accrediting or standard-setting body and poses a potential risk to public health or safety, has engaged in unprofessional conduct, or has acted negligently in treating a patient; or (d) provides to any prospective employer of an employee or former employee of a health care provider or health care facility any information relating to an allegation that the employee or former employee has violated any state or federal law, rule, or regulation, or that there exists any situation in which the quality of any health care service provided by the employee or former employee violated any standard established by any state or federal law or regulation or any clinical or ethical standard established by a professionally accrediting or standard-setting body and posed a potential risk to public health or safety, or that the employee or former employee has engaged in unprofessional conduct, or has acted negligently in treating a patient.

Provide that the immunity from civil or criminal liability described herein does not apply to allegations concerning the health care provider's, health care facility's, or the employee's own treatment of a patient. Further, provide that the health care provider, health care facility or the employee thereof that provides such information to an agency with the authority to investigate such allegations may disclose to the agency the name of the patient at issue and a description of the events giving rise to the allegations, and require the agency to keep such information confidential except for the purpose of investigating and taking action on the alleged violations.

13. PEER REVIEW OF HEALTH CARE PROVIDERS

RLR/ RPN

Senate: No change to Joint Finance.

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Assembly: Modify current law pertaining to information and records retained by organizations and individuals who participate in the review or evaluation of services of health care providers or charges for such services, as follows: (a) expand the list of persons and entities required to keep a record of their investigations, inquiries, proceedings, and conclusions to include all persons, organizations, or evaluators, whether from one or more entities; (b) specify that no such record may be used in any civil or criminal action against the health care provider or facility (current law limits that prohibition to civil actions for personal injuries against the health care provider or facility); (c) modify current law to authorize the release of information acquired in connection with the review and evaluation of health care services in a report in statistical form that is filed with a regulatory agency, accrediting agency, or person that publicly reports quality and patient safety information; and (d) delete the current provision that authorizes the release of information acquired in connection with the review and evaluation of health care services to the court of record in any criminal matter. Further, prohibit any report or information that a state or federal regulatory agency requires a health care provider to give or disclose to that state or federal regulatory agency from being used as

evidence in a civil or criminal action brought against the health care provider, except that such reports and information may be used as evidence in any administrative proceeding conducted by the state regulatory agency.

14. ACCESS TO MEDICAL HEALTH RECORDS

Senate: No change to Joint Finance.

Assembly: Modify current law to include other relevant "medical" information necessary for the current treatment of the individual among the types of treatment records that may be released without informed consent to health care providers in a related health care entity, or to any person acting under the supervision of such a health care provider who is involved with an individual's care, if necessary for the current treatment of the individual.

Under current law, the information that may be released to such persons is limited to: (a) the individual's name, address, and date of birth; (b) the name of the individual's mental health treatment provider; (c) the date of mental health service provided; (d) the individual's medications, allergies, and diagnoses; and (e) other relevant "demographic" information necessary for the current treatment of the individual. This item would substitute the word "medical" for the word "demographic" as it appears in the current statute.

15. EMPLOYERS' USE OF FINANCIAL INCENTIVES TO ENCOURAGE OR DISCOURAGE USE OF A LAWFUL PRODUCT

Senate: No change to Joint Finance.

Assembly: Modify statutes pertaining to employment discrimination to permit employers, labor organizations, employment agencies, licensing agencies, or other persons to offer financial incentives related to employee health care benefits that are intended to encourage or discourage use of a lawful product during nonworking hours. Current law provides that the financial incentives these persons may offer include offering a policy or plan of life, health, or disability insurance under which the type of coverage or the price of coverage differs depending upon the employees' use or nonuse of a lawful product during nonworking hours. This modification would allow employers to offer additional forms of financial incentives to encourage or discourage employees' use of a lawful product.

1. FUNDING FOR THE STATE CENTERS TO PAY THE PROPOSED INCREASE IN THE ICF-MR ASSESSMENT

	Chg. to JFC
PR	$544,400

Senate/Assembly: Provide $544,400 in 2007-08 to enable the three state centers for the developmentally disabled to fully fund the cost of the bed assessment increase that would take effect on July 1, 2007. The PR funding in the JFC substitute amendment was based on the assumption that the increase in the ICF-MR bed assessment would take effect on January 1, 2008, although the provision would take effect on July 1, 2007. This item would correct the amount of PR expenditure authority that would be required for the centers to pay the increased assessments.

2. CENTERS POSITION ADJUSTMENTS DUE TO CIP IA PLACEMENTS

	Chg. to JFC
PR	6.64

Senate/Assembly: Provide an additional 6.64 positions, beginning in 2007-08, for the state centers for the developmentally disabled so that 17.56 positions, rather than 24.20 positions, would be deleted, beginning in 2007-08, due to placements from the centers under the community integration program (CIP IA) that occurred in the 2005-07 biennium. This adjustment would permit DHFS to accomplish the statutory funding reduction, by eliminating fewer, but higher cost vacant positions, than under the JFC substitute amendment.

3. TREATMENT -TO- COMPETENCY SERVICES

Senate: No change to Joint Finance.

	Chg. to JFC
GPR	- $608,000

Assembly: Delete the provision that would provide $262,500 in 2007-08 and $345,500 in 2008-09 to fund treatment-to-competency services, and delete all statutory changes in the bill relating to these services.

Under Chapter 971 of the statutes, if a court determines that a criminal defendant is not competent to stand trial, but is likely to become competent within a period of time not to exceed 12 months or the maximum sentence specified for the most serious offense with which the defendant is charged, whichever is less, the court suspends the criminal proceedings and commits the defendant to the custody of DHFS for placement in an appropriate institution

(currently, one of the state mental health institutes), where the defendant receives treatment-to-competency services.

Joint Finance would provide funding to establish a pilot program in Milwaukee County that would provide treatment-to-competency services in locations other than the state mental health institutes, and permit these services to be provided in other DHFS facilities, jails, or community settings.

4. REQUEST FOR PROPOSAL – PHARMACY SERVICES

Senate: No change to Joint Finance.

Assembly: Require DHFS to issue a request for proposals to provide pharmacy management services for the Winnebago Mental Health Institute and for the Wisconsin Resource Center. Specify that DHFS may prepare an offer to continue to provide pharmacy management services at these facilities, but is not required to do so. Direct DHFS to select the offer that would meet all of the requirements included in the request at the lowest cost to the state. Direct DHFS to offer a one-year contract to the organization that submitted the lowest-cost offer for a period of one year, with an option to renew the contract for three additional one-year periods.

Disability and Elder Services and Departmentwide Services

1. STATE-FUNDED SSI BENEFITS

Senate: Increase estimates of state supplemental security income ~~(SSI)~~ benefits payments by $193,700 in 2007-08 and by $229,300 in 2008-09 to reflect a reestimate of the funding needed to fully fund these benefits in the 2007-09 biennium.

	Chg. to JFC
GPR	$423,000

DHFS makes these monthly payments to approximately 98,000 individuals who receive federal SSI benefits, and 6,900 individuals who do not qualify for the federal benefit but were receiving a partial state benefit as of January 1, 1996, when the state discontinued its state-only benefit for new applicants.

Base funding for these payments is $128,281,600 GPR. The JFC substitute amendment would increase funding by $5,209,600 GPR in 2007-08 and by $7,376,300 GPR in 2008-09. However, it is currently estimated that an additional $193,700 GPR in 2007-08 and $229,300 GPR in 2008-09 would be needed to fully fund projected benefits costs so that a total of $133,684,900 GPR in 2007-08 and $135,887,200 would be provided to support state SSI benefits.

Assembly: No change to Joint Finance.

2. WISCONSIN COUNCIL ON PROBLEM GAMBLING

	Chg. to JFC
PR	$200,000

Senate: Provide $100,000 annually from the lottery fund to the Wisconsin Council on Problem Gambling to increase funding to support staff for a 24-hour hotline that provides assistance to compulsive gamblers and their families. DHFS is currently budgeted $300,000 annually to support the Council.

Assembly: No change to Joint Finance.

3. OUTREACH SERVICES IN SOUTHCENTRAL AND SOUTHEASTERN WISCONSIN

	Chg. to JFC
GPR	$168,000

Senate: Provide $84,000 annually to community organizations in south-central and southeastern Wisconsin to provide outreach services relating to health, mental health, housing, assisted living, domestic violence, and other services.

Assembly: No change to Joint Finance.

4. WISCONSIN COUNCIL ON DEVELOPMENTAL DISABILITIES

	Chg. to JFC
FED	- $3,600

Senate: Delete the JFC provision that would transfer the Wisconsin Council on Developmental Disabilities from DHFS to the Department of Children and Families (DCF), effective July 1, 2008. Instead, create a new state agency, the Board for People with Developmental Disabilities (BPDD), and assign the agency the statutory responsibilities currently assigned to the Council.

Reduce funding for DHFS by $15,000 GPR and $1,271,800 FED in 2007-08 and reduce funding for DCF by $15,000 GPR and $1,268,200 FED in 2008-09 and increase funding for BPDD by $15,000 GPR and $1,268,200 annually. Delete 7.75 FED positions from DHFS in 2007-08 and delete 7.75 FED positions from DCF in 2008-09 and provide 7.75 FED positions to BPDD, beginning in 2007-08. Create GPR and FED appropriations for the BPDD's operations, and a FED appropriation for project aids. Attach BPDD to DOA for administrative purposes only, effective with the passage of the biennial budget bill.

Require DHFS to ensure that the matching funds requirement for the state developmental disabilities councils grant, as received from the U.S. Department of Health and Human Services (DHHS), is met by reporting to DHHS county expenditures for services to persons with developmental disabilities under the community aids program.

Specify that: (a) the assets and liabilities related to the functions of Council would become the assets and liabilities of BPDD; (b) incumbent employees holding positions, relating to the functions of the Council would be transferred to BPDD; (c) transferred employees would have the same rights and status in BPDD that they enjoyed in DHFS, and no employee transferred who has attained permanent status would have to serve a probationary period; (d) all tangible personal property, including records, related to the functions of the Council would be transferred to BPDD; (e) all contracts related to the functions of the Council would remain in effect and would be transferred to BPDD, which would be required to carry out these contractual obligations unless modified or rescinded by BPDD to the extent allowed under the contract.

The Council has recently indicated that the proposed transfer to DCF would likely not be permitted under federal law, since DCF would, under the bill, administer programs supported with federal funds the state receives under the temporary assistance for needy families program.

	Chg. to JFC
FED	$3,600

Assembly: Delete the JFC provision to transfer funding and staff for the Wisconsin Council on Developmental Disabilities from DHFS to the Department of Children and Families (DCF) to reflect the deletion of all of the provisions in the bill that would create DCF. See "Health and Family Services --Children and Families." Instead, retain the Council's staff and funding in DHFS. Increase net funding in the bill by $3,600 FED in 2008-09 to reflect a slight difference in fringe benefit rates budgeted for staff in DHFS, compared with the estimated rates that would apply to DCF staff.

5. QUALITY HOME CARE COMMISSION

Senate: No change to Joint Finance.

	Chg. to JFC
GPR	- $334,000

Assembly: Delete the provision that would provide $167,000 annually for DHFS to distribute to an organization to provide services to consumers and providers of supportive home care and personal care services. This organization is the Quality Home Care Commission.

6. FEMALE OFFENDER REINTEGRATION PROGRAM

Senate: No change to Joint Finance.

	Chg. to JFC
GPR	- $212,800

Assembly: Delete the provision that would authorize DHFS to award up to $106,400 annually as a grant to an organization or group of organizations to provide services for female prisoners and offenders from Milwaukee County and their children, if the prisoners or offenders have been convicted of nonviolent crimes. Instead, eliminate base GPR funding for the

program (-$106,400 annually).

Funding for this purpose was provided on a one-time basis in the 2005-07 biennium. The statutes currently reference funding allocations for 2005-06 and 2006-07. The program provides screening, assessment, and treatment services, including mental health and permanency services, for prisoners and offenders to assist in their reintegration into the community. The GPR funding for the program supports costs that cannot be funded under the federal access to recovery grant or other sources.

7. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT ALLOCATIONS

Senate: No change to Joint Finance.

Assembly: Delete the provision that would require DHFS to annually allocate any funding the state receives that exceeds $6,711,200 FED from the federal community mental health services block grant to community aids, the integrated services program, the consumer and family self-help and peer-supported programs, and protection and advocacy services.

8. NOTIFICATION OF PENDING CARETAKER INVESTIGATION

Senate: No change to Joint Finance.

Assembly: Direct DHFS to modify the registry the Department maintains of persons who have satisfactorily completed a nurse's assistant, home health aide, or hospice aide instructional program and competency evaluation program or only a competency evaluation program to indicate when individuals on the registry are under investigation for charges relating to the abuse or neglect of a patient.

9. STATE OPERATIONS FUNDING REDUCTIONS

Senate: No change to Joint Finance.

Assembly: Reduce funding by $2,288,800 (-$1,315,100 GPR and -$973,700 FED) in 2007-08 and by $3,811,700 (-$2,601,000 GPR and -$1,210,700 FED) in 2008-09 to reflect the following state operations funding reductions.

	Change to JFC Funding	Positions
GPR	- $3,916,100	32.00
FED	- 2,184,400	10.50
Total	- $6,100,500	42.50

FoodShare Contract. Delete $1,032,000 (-$516,000 GPR and -$516,000 FED) in 2007-08 and $2,480,000 (-$1,240,000 GPR and -$1,240,000 FED) in 2008-09 to reflect reestimates of funding that will be needed to support a new vendor contract for FoodShare benefits.

Medicaid Claims Processing -- Enhanced Federal Match. Delete $487,000 GPR and provide $487,000 FED in 2008-09 to reflect GPR savings DHFS anticipates will be realized because a new MA claims processing system will permit DHFS to claim enhanced federal MA funding for certain functions, beginning in 2008-09.

Bureau of Eligibility Management Contracted Positions. Delete $915,400 (-$457,700 GPR and -$457,700 FED) annually to reflect projected savings of converting 21.0 contracted staff positions that currently support the client assistance for reemployment and economic support (CARES) system to state positions (10.5 GPR positions and 10.5 FED positions, beginning in 2007-08).

Bureau of Information Technology Services Contracted Positions. Delete $227,300 GPR in 2007-08 and $302,200 GPR in 2008-09 to reflect projected savings of converting 23.0 contracted staff positions that provide information and technology services, to state positions, beginning in 2007-08,

Office of Strategic Finance. Delete $114,100 GPR annually and 1.5 GPR vacant positions in the Office of Strategic Finance.

10. LIAISON POSITION TO THE GOVERNOR'S OFFICE

Senate: No change to Joint Finance.

	Chg. to JFC
GPR	- $43,400

Assembly: Delete the provision that would extend 1.0 FED agency liaison project position, which serves as a special assistant to the Secretary on program issues, from July 1, 2007, to February 28, 2008. Transfer $43,300 FED in 2007-08 from salaries and fringe benefits to instead support supplies and services in the agency's general management appropriation, and reduce GPR funding for supplies and services by a corresponding amount.

This position, which is supported by federal indirect funds, was created in March, 2004, to serve as the DHFS liaison to the Governor's Office to facilitate sharing of information between the two agencies. The position serves as the special assistant to the Secretary on program issues and policy development, and performs ad hoc projects.

11. UNCLASSIFIED DIVISION ADMINISTRATOR POSITION

Senate: No change to Joint Finance.

	Chg. to JFC
GPR	- 1.00

Assembly: Delete the provision that would create 1.0 unclassified division administrator position, beginning in 2007-08. DHFS intends to divide the Division of Disability and Elder Services (DDES) into two divisions: (a) long-term care; and (b) mental health and substance abuse. This position would serve as a division administrator for one of the new divisions.

Children and Families

1. FOSTER CARE RATES

Senate: No change to Joint Finance.

Assembly: Delete the provision that would increase uniform foster care rates by 5% effective January 1, 2008 and an additional 5% effective January 1, 2009. Instead, increase uniform foster care rates by 5% effective January 1, 2009. Decrease funding in the bill by $557,400 (-$426,000 GPR and -$131,400 FED) in 2007-08 and by $1,566,100 (-$1,189,700 GPR and -$376,400 FED) in 2008-09.

	Chg. to JFC
GPR	- $1,615,700
FED	- 507,800
Total	- $2,123,500

Counties and DHFS make payments to foster parents, treatment foster parents, and family-operated group homes to support food, clothing, housing, personal care, and other expenses for children in foster care. In addition to the basic rate, if a foster child has emotional, behavioral, or medical problems, the foster parents may receive a supplemental or exceptional payment. The basic foster care rates under current law and under this item are shown in the following table.

Basic Monthly Maintenance Payments

Age	Current Law	Proposed CY 2008	Proposed CY 2009
0 thru 4	$317	$317	$333
5 thru 11	346	346	363
12 thru 14	394	394	414
15 and Over	411	411	432

2. FOODSHARE -- EMPLOYMENT AND TRAINING PROGRAM

Senate: No change to Joint Finance.

Assembly: Delete provisions that would: (a) make the food stamp employment and training (FSET) program voluntary; (b) transfer the FSET program from the Department of Workforce Development to DHFS; (c) expand the caretaker exemption that exempts a FoodShare recipient who is the caretaker of a child under the age of 26 weeks from participating in the FSET program; and (d) delete requirements related to compliance with child support as an eligibility criterion for receiving FoodShare benefits.

	Change to JFC Funding	Positions
GPR	$709,200	0.00
FED	709,200	1.00
Total	$1,418,400	1.00

Instead, modify current law to require able individuals who are 18 to 60 years of age who are not participants in a Wisconsin Works employment position to participate in the FSET program if they are required to participate under federal law as a condition of receiving FoodShare benefits. Increase funding in the bill by $709,200 ($354,600 GPR and $354,600 FED) annually and reduce 1.0 FED position, beginning in 2007-08, to reflect these changes.

3. SKILLS ENHANCEMENT PROGRAM

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $1,170,000 annually for DHFS to distribute to community action agencies to support the skills enhancement program, which provides individuals who are working at least 20 hours per week and whose earned income does not exceed 150% of the federal poverty level access to transportation, child care, career, counseling, job placement assistance, and financial support to cover the costs of classes and training to help participants acquire the skills necessary to obtain higher-wage employment.

	Chg. to JFC
GPR	- $2,340,000

4. EARLY CHILDHOOD INITIATIVE -- ALLIED DRIVE (MADISON)

Senate: Provide one-time funding of $250,000 in 2007-08 and 2008-09 to fund the comprehensive early childhood initiative that provides home visiting and employment preparation and support for low-income families in Dane County in order to expand the initiative to one new neighborhood and provide ongoing support for the current Allied Drive early childhood initiative.

	Chg. to JFC
GPR	$500,000

Assembly: No change to Joint Finance.

5. DOMESTIC ABUSE GRANTS

Senate: No change to Joint Finance.

Assembly: Reduce funding that would be provided for domestic abuse grants by $706,600 in 2007-08 and by $567,100 in 2008-09. However, retain the provision that would increase the domestic abuse surcharge from $75 to $100, effective for convictions that occur on or after January 1, 2008, in order to increase funding for grants from this source by $43,400 PR in 2007-08 and $182,900 PR in 2008-09. Consequently, funding for domestic abuse grants would increase by $243,400 ($200,000 GPR and $43,400 PR) in 2007-08 and $382,900 ($200,000 GPR and $182,900 PR) in 2008-09.

	Chg. to JFC
GPR	- $1,273,700

6. POST-ADOPTION RESOURCE CENTERS AND ADOPTION EXCHANGE AND ADOPTION INFORMATION CENTER

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $199,500 ($109,700 GPR and $89,800 FED) in 2007-08 and $212,100 ($116,600 GPR and $95,500 FED) in 2008-09 to increase funding for post-adoption resource centers and the adoption exchange and adoption information center.

	Chg. to JFC
GPR	- $226,300
FED	- 185,300
Total	- $411,600

7. TRANSITION SERVICES FOR FOSTER CARE YOUTH

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $50,000 annually to organizations in Milwaukee County that provide services to aid youth in making the transition from foster care to independent living.

	Chg. to JFC
GPR	- $100,000

8. AUTHORIZE USE OF INCOME AUGMENTATION FUNDS AND EXCESS FEDERAL REVENUES FOR TRIBAL OUT-OF-HOME CARE PLACEMENTS

Senate: No change to Joint Finance.

Assembly: Delete the provision that would authorize DHFS in 2007-08 and the Department of Children and Families (DCF, which would be created in the bill) in 2008-09 to expend up to $500,000 in income augmentation services receipts, MA targeted case management, and excess federal revenues the agency received in fiscal year 2006-07 or 2007-08 for unexpected or unusually high-cost out-of-home care placements of American Indian children ordered by tribal courts.

Spoke to Jim Johnson
They want to delete & lapse to general fund per s. 20.435 (8)(mb)

GMM

USED TRIBAL GAMING $
LRB # 1217 "N"

HEALTHY WISCONSIN AUTHORITY

PJK IRAC

1. CREATE HEALTHY WISCONSIN AUTHORITY AND HEALTHY WISCONSIN PLAN

Senate: Create the Healthy Wisconsin Authority and the Healthy Wisconsin Plan as follows:

	Chg. to JFC
SEG-REV	$7,600,000,000
SEG	$7,600,000,000

Healthy Wisconsin Authority

Board Membership. Create the Health Wisconsin Authority (Authority) as a public body corporate and politic, the Board of Trustees (Board) of which would consist of: (a) five non-voting members, including the Secretary of Employee Trust Funds, who would serve as the initial chairperson until the Board elects a chairperson from its voting members, and four representatives from the Authority's health care advisory committee who are health care personnel and administrators and who would be selected as Board members by the health care advisory committee; and (b) 16 voting members, nominated by the Governor and appointed with the advice and consent of the Senate, comprised of: (1) four members selected from a list submitted by statewide labor or union coalitions, one of which would be a public employee; (2) four members selected from a list submitted by statewide business and employer organizations, one of which would be a public employer; (3) one member selected from a list submitted by statewide public school teacher labor organizations; (4) one member selected from a list submitted by statewide small business organizations; (5) two members who are farmers, selected from a list submitted by statewide general farm organizations; (6) one member who is a self-employed person; and (7) three members selected from a list submitted by statewide health care consumer organizations. Specify that Board members would serve staggered terms of six years each. Authorize the Board to appoint an Executive Director, who would serve at the Board's pleasure, and whose compensation would be determined by the Board.

Board Responsibilities. Charge the Board with the duty to establish, fund, and administer a health care system in Wisconsin that would ensure that all eligible persons have access to high quality, timely, and affordable health care. Direct the Board, in carrying out that duty, to seek to attain the following goals: (a) that every Wisconsin resident has access to affordable, comprehensive health care services; (b) that health care reform would maintain and improve the choice of health care providers and high quality health care services in Wisconsin; and (c) that health care reform would implement cost containment strategies that retain and assure affordable coverage for all Wisconsin residents.

Require the Board to do the following: (a) provide for mechanisms to enroll into the Healthy Wisconsin Plan (plan) every eligible Wisconsin resident; (b) create a program for consumer protection and a process to resolve disputes with providers; (c) establish an

independent and binding appeals process for resolving disputes over eligibility and other determinations made by the Board, and entitle individuals adversely affected by any such determination to judicial review of the determination; (d) submit an annual report on the Board's activities to the Governor and each house of the Legislature; (e) contract for annual, independent program evaluations and financial audits that measure the extent to which the plan is achieving its statutorily-defined goals; (f) accept bids from health care networks, or make payments to fee-for-service providers, upon consulting with the Department of Employee Trust Funds to determine the most effective and efficient way to purchase health care benefits; and (g) audit health care networks and providers to determine if their services meet the plan's statutory objectives and criteria.

Vest the Board with all powers necessary or convenient to carry out the plan's statutory purposes and provisions. Specify that those powers would include, but not be limited to, the power to establish the Authority's annual budget and monitor its fiscal management, to execute contracts, to employ any Officers, agents, and employees it may require, to sue and to be sued, to borrow money as necessary on a short-term basis to address cash flow issues, and to compel witnesses to attend meetings and to testify upon any necessary matter concerning the plan.

Healthy Wisconsin Trust Fund. Create the Healthy Wisconsin Trust Fund (fund) as a separate, nonlapsible trust fund consisting of all moneys appropriated or transferred to or deposited in the fund. Establish from the fund a sum sufficient appropriation to pay the Authority for the operation and funding of the plan.

Health Care Advisory Committee. Require the Board to establish a health care advisory committee to advise the Board on all the following issues: (a) matters related to promoting healthier lifestyles; (b) promoting health care quality; (c) increasing the transparency of health care cost and quality information; (d) preventive care; (e) early identification of health disorders; (f) disease management; (g) appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms; (h) confidentiality of medical information; (i) appropriate use of technology; (j) benefit design; (k) availability of physicians, hospitals, and other providers; (l) reducing health care costs; (m) any other subject assigned to it by the Board; and (n) any other subject determined appropriate by the committee.

Direct the Board to appoint as members of the health care advisory committee all the following individuals: (a) at least one member designated by the Wisconsin Medical Society, Inc.; (b) at least one member designated by the Wisconsin Academy of Family Physicians; (c) at least one member designated by the Wisconsin Hospital Association, Inc.; (d) one member designated by the President of the Board of Regents of the University of Wisconsin System who is knowledgeable in the field of medicine and public health; (e) one member designated by the President of the Medical College of Wisconsin; (f) two members designated by the Wisconsin Nurses Association, the Wisconsin Federation of Nurses and Health Professionals, and the Service Employees International Union; (g) one member designated by the Wisconsin Dental Association; (h) one member designated by statewide organizations interested in mental health

issues; (i) one member representing health care administrators; and (j) other members representing health care professionals.

Office of Outreach, Enrollment, and Advocacy. Direct the Board to establish an Office of Outreach, Enrollment, and Advocacy (Office). Require the Office to contract with nonprofit organizations, but not an organization that provides services under the plan or that has any other conflict of interest, to perform the following outreach, advocacy, and enrollment functions: (a) engage in aggressive outreach to enroll eligible persons and participants in their choice of health care coverage under the plan; (b) assist eligible persons in choosing health care coverage by examining cost, quality, and geographic coverage information regarding their choice of available networks or providers; (c) inform plan participants of the role they can play in holding down health care costs by taking advantage of preventive care, enrolling in chronic disease management programs if appropriate, responsibly utilizing medical services, engaging in healthy lifestyles, and inform participants of networks or workplaces where healthy lifestyle incentives are in place; (d) at the direction of the Board, establish a process for resolving disputes with providers; (e) act as an advocate for plan participants having questions, difficulties, or complaints about their health care services or coverage, investigate the complaint, including, when appropriate, consulting with the health care advisory committee regarding best practice guidelines, and attempt to resolve the complaint; (f) if a participant's complaint cannot be successfully resolved, inform the participant of any legal or other means of recourse for his or her complaint, including , where applicable, the appeals process for Board decisions; (g) provide information to the public, agencies, legislators, and others regarding problems and concerns of plan participants, and, in consultation with the health care advisory committee, make recommendations for resolving those problems and concerns; and (h) ensure that plan participants have timely access to the services provided by the Office.

Prohibit the Office and its employees and contractors from having any conflicts of interest relating to the performance of their duties. Define a conflict of interest for these purposes as any of the following: (a) direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or health care provider; (b) direct ownership interest or investment interest in a health care facility, health insurer, or health care provider; (c) employment by, or participation in the management of a health care facility, health insurer, or health care provider; or (d) receipt of, or having the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

Healthy Wisconsin Plan

Eligibility for Participation in the Plan. Establish eligibility criteria that would make a person eligible to participate in the plan if they satisfy all the following: (a) they have maintained their place of permanent abode in this state for at least 12 months; (b) they maintain a substantial presence in this state; (c) they are under age 65; (d) they are not eligible for health care coverage from the federal government or a foreign government, they are not an inmate of a

penal facility, and they are not placed or confined in, or committed to, an institution for the mentally ill or the developmentally disabled; and (e) unless a waiver request has been granted by the Secretary of the U.S. Department of Health and Human Services and is in effect, they are not eligible for medical assistance or for health care coverage under the BadgerCare health care program.

In addition, designate the following persons as eligible to participate in the plan: (1) a person and the members of that person's immediate family, if the person is gainfully employed in Wisconsin and the person and the members of the person's immediate family satisfy criteria (c) through (e); (2) a child under age 18 who resides with his or her parent in Wisconsin, even if the parent does not yet satisfy criteria (a), regardless of how long the child has resided in Wisconsin; and (3) a pregnant woman who resides in Wisconsin, even if the woman does not yet satisfy criteria (a), regardless of how long the woman has resided in Wisconsin.

Prohibit any person who is otherwise eligible to participate in the plan, but who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2009, from being eligible to participate in the plan until the day on which the collective bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified, or renewed.

For purposes of establishing the plan's eligibility criteria, require the Board to define the terms "place of permanent abode," "immediate family," and "gainfully employed," the latter of which must include employment by persons who are self-employed and persons who work on farms. Require the Board to also define the term "substantial presence in this state," and in so doing, consider such factors as the amount of time per year the person is actually present in the state and the amount of taxes the person pays in the state, except that if the person attends school outside this state and is under age 23, the factors would include the amount of time the person's parent or guardian is actually present in the state and the amount of taxes the person's parent or guardian pays in the state, and if the person is in active service with the U.S. armed forces outside this state, the factors would include the amount of time the person's parent, guardian, or spouse is actually present in this state and the amount of taxes the individual's parent guardian or spouse pays in this state.

Waiver Request. Require the Department of Health and Family Services (DHFS) to develop a request for a waiver from the Secretary of the U.S. Department of Health and Human Services to provide coverage under the plan to individuals who are eligible for medical assistance in the low-income families category, as determined by DHFS, and to individuals who are eligible for health care coverage under the BadgerCare health care program. Require the waiver request to be written so as to allow the use of federal financial participation to fund, to the maximum extent possible, health care coverage under the plan for these individuals. Further, require DHFS to submit the waiver request, not later than July 1, 2008, to a special legislative committee comprised of the members of the Joint Committee on Finance and members of the standing committees of the Senate and Assembly with subject jurisdiction over

health issues, which would have 60 days to review and comment to DHFS on the waiver request. Authorize DHFS to develop other waiver requests to appropriate federal agencies so as to permit funds from federal health care services programs to be used for health care coverage for persons under the plan.

Benefits. Require the Board to establish a health care plan that will take effect on January 1, 2009 and that will provide the same benefits as those that were in effect as of January 1, 2007, under the state employee health plan. Authorize the Board to adjust the plan benefits to provide additional cost-effective treatment options if there is evidence-based research that the options are likely to reduce health care costs, avoid health risks, or result in better health outcomes. In addition, require the plan to provide coverage for mental health services and alcohol or other drug abuse treatment to the same extent as the plan covers treatment for physical conditions, and to provide coverage for preventive dental care for children up to 18 years of age.

Require the plan to cover the following preventive services without any cost-sharing requirement: (a) prenatal care for pregnant women; (b) well-baby care; (c) medically appropriate examinations and immunizations for children up to 18 years of age; (d) medically appropriate gynecological exams, Papanicolaou tests, and mammograms; (e) medically appropriate regular medical examinations for adults, as determined by best practices; (f) medically appropriate colonoscopies; (g) preventive dental care for children up to 18 years of age; (h) other preventive services or procedures, as determined by the Board, for which there is scientific evidence that exemption from cost sharing is likely to reduce health care costs or avoid health risks; and (i) chronic care services, provided that the participant receiving the services is participating in, and complying with, a chronic disease management program as defined by the Board.

Deductibles. Specify that during any year, the following deductibles would apply to all covered services and articles: (a) $300 for a participant who is 18 years of age or older on January 1 of that year; (b) $600 for a family consisting of two or more participants who are 18 years of age or older on January 1 of that year; and (c) $0 for a participant who is under 18 years of age on January 1 of that year. Authorize the Board to adjust the plan's deductible amounts, but only to reduce those amounts. Except for copayments and coinsurance, require the plan to provide a participant with full coverage for all covered services and articles after the participant has received covered services and articles totaling the applicable deductible amount, regardless of whether the participant has paid the deductible.

Require providers that provide to a participant a covered service or article to which a deductible applies to charge, and to accept as full payment for that service or article, the payment rate established by the Board.

Except for prescription drugs, prohibit a provider from refusing to provide to a participant a covered service or article to which a deductible applies on the basis that the

participant does not pay, or has not paid, any applicable deductible amount before the service or article is provided. Further, prohibit a provider from charging any interest, penalty, or late fee on any deductible amount owed by a participant unless the deductible amount is at least six months past due and the provider has provided the participant with notice of the interest, penalty, or late fee at least 90 days before the interest, penalty, or late fee payment is due. Prohibit any such interest charges to exceed 1% per month, and any penalty or late fee to exceed the provider's reasonable cost of administering the unpaid bill.

Copayments and Coinsurance. Establish the following copayment and coinsurance requirements under the plan.

- General copayments. During any year, a participant who is 18 years of age or older on January 1 of that year would pay a copayment of $20 for medical, hospital, and related health care services, as determined by the Board;

- Specialist provider services without referral. A participant, regardless of age, who receives health care services from a specialist provider without a referral from his or her primary care provider under the plan would be required to pay 25% of the cost of the services provided;

- Inappropriate emergency room use. A participant who is 18 years of age or older would pay a copayment of $60 for inappropriate emergency room use, as determined by the Board;

- Prescription drugs. All participants, regardless of age, would pay $5 for each prescription of a generic drug that is on the formulary determined by the Board, $15 for each prescription of a brand-name drug that is on the formulary determined by the Board, and $40 for each prescription of a brand-name drug that is not on the formulary determined by the Board. Authorize the Board to adjust the plan's copayment and coinsurance amounts.

Maximum Out-of-Pocket Amounts. Specify that, notwithstanding the deductible, coinsurance, and copayment amounts described above, a participant who is 18 years of age or older on January 1 of that year would not be required to pay more than $2,000 a year in total cost sharing, and a family consisting of two or more participants would not be required to pay more than $3,000 a year in total cost sharing.

Service Areas, Selection, and Payment of Health Care Providers and Health Care Networks. Define a "health care network" as a provider-driven, coordinated group of health care providers comprised of primary care physicians, medical specialists, physician assistants, nurses, clinics, one or more hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment.

Authorize the Board to establish areas in the state for the purpose of receiving bids from health care networks so as to maximize the level and quality of competition among health care networks or to increase the number of provider choices available to eligible persons and participants in the areas.

Require the Board, in each such designated area, to offer both of the following options for delivery of health care services under the plan: (a) a fee-for-service option, under which participants would choose a primary care provider, may be referred by the primary care provider to any medical specialist, and may be admitted by the primary care provider or specialist to any hospital or other facility, for the purpose of receiving the benefits provided under the plan. Under this option, the Board, with the assistance of one or more administrators chosen by a competitive bidding process and with whom the Board has contracted, would pay directly, at the provider payment rates established by the Board, for all health care services and articles that are covered under the plan; and (b) an option under which one or more health care networks that meet the qualifying criteria, and are certified by the Board, provide health care services to participants. Require the Board to offer option (b) in each area designated by the Board to the extent qualifying health care networks exist in that area.

Solicitation of Bids from Health Care Networks. Require the Board to annually solicit sealed risk-adjusted premium bids from competing health care networks for the purpose of offering health care coverage to participants. Require the Board to request each bidder to submit information pertaining to whether the bidder is a qualifying health care network. A health care network would be deemed a qualifying health care network if it does all the following:

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

(b) spends at least 92% of the revenue it receives under the plan on payments to health care providers in order to provide the health care benefits specified under the plan to participants who choose the health care network, or on investments the health care network has reasonably determined will improve the overall quality or lower the overall cost of patient care;

(c) ensures that participants living in an area that a health care network serves would not be required to drive more than 30 minutes, or in a metropolitan area served by mass transit, spend more than 60 minutes using mass transit facilities, in order to reach the offices of at least two primary care providers, as defined by the Board;

(d) ensures that physicians, physician assistants, nurses, clinics, hospitals, and other health care providers and facilities that specialize in mental health services and alcohol or other

drug abuse treatment are conveniently available, as defined by the Board, to participants living in every part of the area the health care network serves;

(e) ensures that participants have access, 24 hours a day, seven days a week, to a toll-free hotline and help desk that is staffed by persons who live in the area and who have been fully trained to communicate the benefits provided under this plan and the choices of providers that participants have in using the health care network;

(f) ensures that each participant who chooses the health care network selects a primary care provider who is responsible for overseeing all the participant's care;

(g) provides each participant with medically appropriate and high-quality health care, including mental health services and alcohol or other drug abuse treatment, in a highly coordinated manner;

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

(i) has developed and is implementing a program, including providing incentives to providers when appropriate, to promote health care quality, increase the transparency of health care cost and quality information, ensure the confidentiality of medical information, and advance the appropriate use of technology;

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

(k) has in place a comprehensive, shared, electronic patient records and treatment tracking system and an electronic provider payment system;

(l) has adopted and implemented a strong policy to safeguard against conflicts of interest;

(m) has been organized by physicians or other health care providers, a cooperative, or an entity whose mission includes improving the quality and lowering the cost of health care, including the avoidance of unnecessary operating and capital costs arising from inappropriate utilization or inefficient delivery of health care services, unwarranted duplication of services and infrastructure, or creation of excess capacity;

(n) agrees to enroll and provide the benefits specified under the plan to all participants who choose the network, regardless of the participant's age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status, except that a health care network may limit the number of new enrollees it accepts if the health care network certifies to the Board that accepting more than a specified number of enrollees would make it impossible to provide all enrollees with the benefits specified under the plan at the level of quality that the network is committed to maintaining, provided that the health care network uses a random method for deciding which new enrollees it accepts. A health care network may also limit the participants it serves to a specific affinity group, such as farmers or teachers, that is in existence as of December 31, 2007 and that the health care network has certified to the Board, provided the limitation does not involve discrimination based on any of the factors described above and has neither been created for the purpose, nor will have the effect, of screening out higher-risk enrollees.

Certification of Health Care Networks and Classification of Bids. Require the Board to review the information submitted pertaining to bidding health care networks, and based on that information, to certify which health care networks are qualifying health care networks. With respect to all such qualifying health care networks, require the Board to open the submitted, sealed bids at a predetermined time. Require the Board to classify the certified health care networks according to price and quality measures after comparing their risk-adjusted per-month bids and assessing their quality. Require the Board to classify the network that bid the lowest price as the lowest-cost network, and to classify as a low-cost network any network that has bid a price that is close to the price bid by the lowest-cost network. Any other network would be classified as a higher-cost network.

Open Enrollment. Require the Board to provide an annual open enrollment period, during which each participant may select a certified health care network from among those offered, or a fee-for-service option, with coverage being effective on the following January 1. Specify that a participant who does not select a certified health care network or the fee-for-service option would be assigned randomly to one of the networks that has been classified as having submitted the lowest or a low bid and as performing well on quality measures, or to the fee-for-service option if that is the lowest-cost option. Further, specify that a participant who selects the fee-for-service option or a certified health care network that has been classified as a higher-cost network, but who fails to pay the additional payment required under the plan, would be assigned randomly to one of the networks that has been classified as the lowest-cost or as a low-cost network and as performing well on quality measures, or to the fee-for-service option if that is the lowest-cost option.

Payments to Networks and Providers. Require the Board, on behalf of each participant who selects or who has been assigned to a certified health care network that has been classified as the lowest-cost network or a low-cost network and as performing well on quality measures, to pay monthly to the health care network the full risk-adjusted per-member per-month amount that was bid by the network, the dollar amount of which would be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the Board. A participant who selects or is assigned to the lowest-cost network or a low-cost network would not be required to pay any additional amount to the network.

Provide that if a participant chooses to enroll in a certified health care network that has been classified as a higher-cost network, the Board would pay monthly to the chosen health care network an amount equal to the bid submitted by the network that the Board classified as the lowest-cost network and as having performed well on quality measures, the dollar amount of which would be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the Board. Require a participant who chooses to enroll in a higher-cost network to pay monthly, in addition to the amount paid by the Board, a payment sufficient to ensure that the chosen network receives the full bid price by that network.

Authorize the Board to retain a percentage of the dollar amounts established for each participant to pay to certified health care networks that have incurred disproportionate risk not fully compensated for by the actuarial adjustment in the amount established for each eligible person. Require that any such payment to a certified health care network reflect the disproportionate risk incurred by the health care network.

Payments to Fee-For-Service Providers. Require the Board to establish provider payment rates that will be paid to providers of covered services and articles that are provided to participants who choose the fee-for-service option that are fair and adequate to ensure that this state is able to retain the highest quality of medical practitioners. Limit increases in the provider payment rate for each service or article such that any increase in per person spending under the plan does not exceed the national rate of medical inflation. Except for deductibles, copayments, coinsurance, and any other cost-sharing required or authorized under the plan, require a provider of a covered service or article to accept as payment in full for the covered service or article the payment rate determined by the Board, and prohibit the provider from billing a participant who receives the service or article for any amount by which the charge for the service or article is reduced.

Require the Board, with the assistance of its actuarial consultants, to establish the monthly risk-adjusted cost of the fee-for-service option offered to participants under the plan, and to classify the fee-for-service option in the same manner the Board classifies certified health care networks. If the Board determines there is at least one certified low-cost health care network in an area, which may be the lowest-cost health care network, and if the fee-for-service option offered in that area has been classified as a higher-cost choice, the cost to a participant enrolling in the fee-for-service option would be determined as follows:

(a) if there are available to the participant three or more certified health care networks classified as low-cost networks, or as the lowest-cost network and two or more low-cost networks, the participant would pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established for the fee-for-service option, except that the amount paid may not exceed $100 per month for an individual, or $200 per month for a family, as adjusted for medical inflation;

(b) if there are available to the participant two certified health care networks classified as low-cost networks, or as the lowest-cost network and one low-cost network, the participant would pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established for the fee-for-service option, except that the amount paid may not exceed $65 per month for an individual, or $125 per month for a family, as adjusted for medical inflation;

(c) if there is available to the participant only one certified health care networks classified as a low-cost network, or as the lowest-cost network, the participant would pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established for the fee-for-service option, except that the amount paid may not exceed $25 per month for an individual, or $50 per month for a family, as adjusted for medical inflation; and

(d) if the Board has determined there is no certified lowest-cost health care network or low-cost health care network in the area, there would be no extra cost to the participant enrolling in the fee-for-service option.

Incentive Payments to Fee-for-Service Providers. Encourage health care providers and facilities providing services under the fee-for-service option to collaborate with each other through financial incentives established by the Board. Require providers to work with facilities to pool infrastructure and resources, to implement the use of best practices and quality measures, and to establish organized processes that will result in high-quality, low-cost medical care. Require the Board to establish an incentive payment system for complying providers and facilities, in accordance with criteria established by the Board.

Pharmacy Benefit. Except for prescription drugs to which a deductible applies, require the Board to assume the risk for, and pay directly for, prescription drugs provided to participants. In implementing this requirement, direct the Board to replicate the prescription drug buying system developed by the Group Insurance Board for prescription drug coverage under the state employee health plan, unless the Board determines another approach would be more cost-effective. Authorize the Board to join the prescription drug purchasing arrangement under the plan with similar arrangements or programs in other states to form a multi-state purchasing group to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices, or to contract with a third party, such as a private pharmacy benefits

manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

Subrogation. Entitle the Board and the Authority to the right of subrogation for reimbursement to the extent that a participant may recover reimbursement for health care services and items in an action or claim, against any third party.

Employer-Provided Health Care Benefits. Provide that nothing under the plan would prevent an employer, or a Taft-Hartley trust on behalf of an employer, from paying all or part of any cost sharing under the plan, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

Assessments on Individuals. For an employee (defined as an individual who has an employer), require the Board to calculate the following assessments, based on its anticipated revenue needs. For an employee who is under age 65, a percent of social security wages that is at least 2% and not more than 4%, subject to the following: (a) if the employee's social security wages are 150% or less of the federal poverty level (FPL), the employee may be not be assessed; (b) if the employee has no dependents and his or her social security wages are more than 150% and 200% or less of the FPL, the assessment would be in an amount, as determined by the Board on a sliding scale based on the employee's social security wages, that is between 0% and 4% of the employee's social security wages; (c) if the employee has one or more dependents, or the employee is a single individual who is pregnant, and their social security wages are more than 150% and 300% or less of the FPL, the assessment would be in an amount as determined by the Board on a sliding scale based on the employee's social security wages, that is between 0% and 4% of the employee's social security wages.

For a self-employed individual (defined as an individual who is required under the Internal Revenue Code to file Schedule SE) who is under age 65, a % of social security wages that is at least 9% and not more than 10%.

For an eligible individual who has no social security wages, 10% of federal adjusted gross income, up to the maximum amount of income that is subject to social security tax.

Assessments on Employers. For an employer, require the Board to collect an assessment, based on the Board's anticipated revenue needs, that is a % of aggregate social security wages that is at least 9% and not more than 12%.

Collection and Calculation of Assessments. For taxable years beginning after December 31, 2008, require the Department of Revenue (DOR) to impose on, and collect from, individuals the assessment amounts the Board calculates either through an assessment that is collected as part of the income tax, or through another method devised by DOR. For taxable years beginning after December 31, 2008, require DOR to impose on, and collect from, employers the assessment amounts the Board calculates either through an assessment that is collected as part of the

taxation of corporations, or through another method devised by DOR. Require DOR to deposit these assessment amounts into the fund.

Require the Secretary of the Department of Administration (DOA Secretary) to establish a methodology for allocating employer assessments among state agencies to the fund for the operation and funding of the plan. Require state agencies to pay, from appropriations used to fund fringe benefit costs of state employees, to the fund the amounts determined by the DOA Secretary.

Require the DOA Secretary, in consultation with the Authority's Board, to establish by rule a program to contain health care costs in Wisconsin during any year in which the Board determines that health care costs increase at a rate exceeding the national average of medical inflation.

Authorize the Board to annually increase or decrease the amounts that may be assessed, provided, however, that no annual increase may exceed the percentage increase for medical inflation unless a greater increase is provided for by law.

Public Employers. Generally, the effect of the amendment would be to include the active employees of public employers (state and local) under the age of 65 in the Healthy Wisconsin Plan. Active employees over the age of 65 would continue to be covered under current law provisions for health insurance coverage provided by public employers to its employees.

The state would be authorized to continue to offer health care coverage under current law provisions to active state employees who are 65 years and older, certain non-state Wisconsin Retirement System (WRS) annuitants, certain elected and executive officials who have left state service, retired state employees, or an employee of the state who terminates creditable service after attaining 20 years of creditable service, remains a WRS participant, and is not eligible for an immediate annuity. Provide that current law provisions relating to the initial state contributions for health care coverage and the level of such contributions would only apply to those state employees not covered under the Healthy Wisconsin Plan (that is, for employees over the age of 65). Provide that the standard health insurance plan in which all insured employees must participate except as otherwise provided in law, must not provide employees any health care coverage that the employees receive under the Healthy Wisconsin Plan.

Provide that any state or local governmental employee covered under the Healthy Wisconsin Plan may not receive coverage under plans offered by the Group Insurance Board (GIB). Provide that the GIB may provide state and local governmental employees with coverage for benefits not provided under the Healthy Wisconsin Plan. These supplemental benefits would be required to conform to certain insurance standards set in current law.

Provide that current law provisions for the payment of health insurance premiums for state employees activated for military duty would not apply to an eligible employee who is

receiving health care coverage under the Healthy Wisconsin Plan. Provide that, if a health care coverage program is developed under the Private Employer Health Care Purchasing Alliance (which is currently inactive), the coverage may not provide employees any health care coverage that the employees receive under the Healthy Wisconsin Plan.

Further, as under current law, a local governmental units (a city, village, town, county, school district, sewerage district, drainage district, and, without limitation because of enumeration, any other political subdivision of the state) may provide for the payment of premiums for hospital and surgical care for its retired employees. For its employees covered under the Healthy Wisconsin Plan, provide that local units may only provide health care benefits that are not provided under the Healthy Wisconsin Plan. This provision applies to self-insured plans and joint self-insured plans of local governmental units. These supplemental benefits would be required to conform to certain insurance standards set in current law.

State Employment Labor Relations Law. Provide that the state as an employer would be prohibited from bargaining on health care coverage of employees under the Healthy Wisconsin Plan.

Well-Woman MA. Amend current law to specify that any woman covered under the plan is not eligible for services for the treatment of breast or cervical cancer or for a precancerous condition of the breast or cervix under the well woman medical assistance program.

BadgerCare Cost Sharing. Repeal the provision in current law that requires certain recipients of health care coverage under the BadgerCare program to pay up to 5% of their income toward the cost of the health care coverage provided under that program.

Disease Aids Program. Amend current law to specify that a person is not ineligible to receive aid for services related to the treatment of chronic renal disease, adult cystic fibrosis, or hemophilia under the disease aids program by virtue of being eligible for, or having coverage under the plan.

Health Insurance Risk-Sharing Plan. Amend current law to specify that any person eligible for coverage under the plan is not eligible for the health insurance plans offered by the Health Insurance Risk-Sharing Plan Authority .

Defined Network Plans. Amend Chapter 609 of the statutes, relating to defined network plans, as follows: (a) repeal the definition of a standard plan to mean a health care plan other than a health maintenance organization or a preferred provider plan; (b) repeal the requirement that an employer that offers any of its employees a health maintenance organization or a preferred provider plan that provides comprehensive health care services must, in some circumstances, also offer the employees a standard plan that provides at least substantially equal coverage of health care expenses and a point-of-service plan; and (c) repeal the statutory

direction to the Commissioner of Insurance to promulgate rules regarding the requirement referenced in (b).

Commissioner of Insurance. Repeal current statutory provisions that require the Commissioner of Insurance to do the following: (a) provide information and assistance to the Department of Employee Trust Funds to facilitate the development and implementation of innovative approaches to the delivery of health care services, and to increase awareness and understanding among employers and their employees, providers of health care services and members of the public regarding the availability and nature of innovative or cost-effective health care plans; (b) assist the Department of Employee Trust Funds in developing health care plans that employers can offer their employees through a program offered by the Group Insurance Board; and (c) provide employers and employees information regarding the plans referenced in (b).

Restrictions on Health Care Services. Amend current law to remove, where applicable, references to health care benefit plans provided on a self-insured basis by school districts, cities, county boards, villages, political subdivisions, and towns in connection with coverage requirements relating to the following: (a) Papanicolaou tests, pelvic examinations, or associated laboratory fees; (b) blood tests for lead for children under six years of age; (c) diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders; and (d) appropriate and necessary immunizations, from birth to the age of six years, for a dependent who is a child of the insured.

Exclusion of Policies that Provide Only Health Care Benefits Not Provided Under the Plan. Amend current law to exclude disability insurance policies that provide only health care benefits not provided under the plan from the requirement to provide coverage for the following: (a) two examinations by low-dose mammography to a woman when that woman is age 45 to 49; (b) drugs prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, as provided in stature; (c) blood lead tests for children under six years of age; (d) diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders; and (e) appropriate and necessary immunizations, from birth to the age of six years, for a dependent who is a child of the insured.

Property Tax Exemption. Create a property tax exemption for all property owned by the Healthy Wisconsin Authority, if the property's use is primarily related to the purposes of the Authority, effective on July 1, 2007, or on the day after publication of the act, whichever is later.

Property Tax Credit. Require any taxing jurisdiction that reduces the cost of providing health care coverage to its employees in 2009 as a result of providing coverage under the Healthy Wisconsin Plan, together with any supplemental coverage needed to ensure that the health care coverage provided to the jurisdiction's employees is actuarially equivalent to the coverage they received in 2008, to distribute 50% of those savings in the form of a property tax credit on tax bills issued in 2009. Require the tax credit to be used to reduce taxes otherwise

payable and to be distributed proportionately to all property owners in the taxing jurisdiction on the basis of equalized values.

Other Provisions. In addition to the provisions summarized above, make the Authority subject to, or exempt from, various state laws, including the following: (a) include the Authority within the definition of an "agency" for purposes of state laws regulating lobbying; (b) require the Legislative Audit Bureau, annually, to conduct a financial audit of the plan, and to charge the Authority for the cost of those audits; (c) require the Authority to provide the Legislative Fiscal Bureau access to any books, records, or other documents maintained by the Authority and relating to its expenditures, revenues, operations, and structure; (d) require the Authority to provide the DOA Secretary access to the Authority's books and accounts and to cooperate with the DOA Secretary with respect to the Secretary's requests, and (d) exempt the Authority from general property taxes, state income and franchise taxes, and other taxes as set forth in the bill.

Effective Date. Most of these provisions, including the provisions relating to coverage under the plan, the Department of Revenue's authority to impose and collect assessments to fund the plan, and changes to coverage under other health plans, would take effect on January 1, 2009, except the provisions relating the creation and operation of the Authority, which would take effect on the bill's general effective date.

Fiscal Effect

The Lewin Group, a national health care and human services consulting firm, has prepared an actuarial analysis of the Wisconsin Health Plan. That analysis, dated June 19, 2007, estimates that approximately 3.8 million individuals would be enrolled in the plan. That estimate, as well as the cost and revenue estimates summarized below, are premised in part upon the state obtaining a waiver from the Secretary of the U.S. Department of Health and Human Services that would expand the eligibility criteria for the state's medical assistance program to include families and pregnant women with household income up to 300% of the federal poverty level (FPL), and to include non-custodial adults with household income up to 200% of the FPL. The Lewin analysis assumes that if that waiver is granted, the number of individuals enrolled in the state's medical assistance and BadgerCare programs would increase by approximately 261,000 from current enrollment levels.

Lewin's analysis estimates that the plan's annual costs (based on calendar year 2007 figures) would total approximately $15.2 billion during its first year of operation, comprised of the following expenditure categories:

Estimated Plan Costs (2007)
($ in Millions)

Program Benefits Payments	$13,679
Program Administrative Costs	315
Insurer Administration Costs	484
Costs Associated with Cap on Premiums for Higher Cost Plans	95
Total Program Costs for WI Residents	$14,573
Costs Associated with Eligible Individuals who are not WI Residents	639
Total Program Costs	$15,212

Lewin's analysis indicates that these program costs would be funded through the following assessment revenues generated under the plan. In the following table, the numbers in parentheses indicate the assumed plan assessment stated as a percent of social security wages:

Estimated Plan Revenues (2007)
($ in Millions)

Private Employers Assessment (10.5%)	$8,868
Sole Proprietor Assessment (10.0%)	685
Employee Assessment (4.0%)	3,590
State and Local Government Assessment (10.5%)	1,332
Special Assessment	98
Total Assessments on WI Employers and Residents	$14,573
Assessments on Eligible Individuals who are not WI Residents	639
Total Program Assessments	$15,212

According to Lewin's analysis, state and local governments would save approximately $1.36 billion in health care costs during the plan's first year of operation, savings Lewin estimates would result from the fact that the plan's assessments, and the supplemental coverage these entities would purchase for their employees, retirees and dependents, would be less than the amounts those entities currently pay in health care costs for those individuals. In part, this savings is due to the fact that some of these individuals will assume a greater portion of their health care costs than is currently the case. In addition, it is estimated that the plan would reduce the shifting of health care costs to state and local plans that occurs under current law. The Lewin analysis further assumes that pursuant to provisions in the proposal, one-half of

those savings, or approximately $680 million, would by used by taxing jurisdictions to reduce property taxes to households ($490 million) and businesses ($190 million) in 2009.

In addition to the estimated savings for public employers, Lewin's analysis also estimates that private employers that currently provide health insurance coverage to their employees will, in the aggregate, reduce their health costs under the plan. Conversely, private employers that currently do not provide health insurance coverage to their employees will, according to Lewin, incur additional costs as a result of mandatory payroll assessment.

With respect to the uninsured, Lewin's analysis estimates that the number of individuals in Wisconsin without health insurance would decline from approximately 476,000 to 15,000 during the plan's first year of operation.

Finally, with respect to total health care spending in this state, Lewin's analysis estimates that total spending on health care in Wisconsin will decline by $751 million during the plan's first year. Lewin estimates that those savings would be achieved through a variety of factors, including primary care emphasis, central purchasing of prescription drugs, and lower administrative costs.

The proposal would not provide funding to support the Authority's activities prior to January 1, 2009, nor does it provide an estimate of what those costs might be. However, the Authority would be permitted to borrow moneys, on a short-term basis, to address cash flow issues.

Based on the estimates provided in the Lewin Study, and the January 1, 2009, effective date for these provisions, it is estimated that this proposal would increase segregated revenue to the fund by $7.6 billion and increase SEG expenditures by a corresponding amount in 2008-09.

Legislative Findings

In establishing the Healthy Wisconsin Plan, create session law provisions that state the following legislative findings.

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

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

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

c. employee premium contributions and out-of-pocket costs are rising faster than wages.

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

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

f. the costs of health services provided to individuals who are unable to pay are shifted to others. Of the $22 billion charged by hospitals in 2005, $736,000,000 was not collected. Those who bear the burden of this cost shift have an increasingly difficult time paying their own health care costs.

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

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

b. over 65% of the uninsured in Wisconsin are employed.

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

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

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

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

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

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

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

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

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

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

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

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

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

Assembly: No change to Joint Finance.

INSURANCE

1. INSURANCE FINANCIAL EXAMINER - CHIEF

Senate: No change to Joint Finance.

Assembly: Delete the provision that would provide $75,900 in 2007-08 and $91,900 in 2008-09 to support 1.0 additional insurance financial examiner-in-chief position, beginning in 2007-08.

	Change to JFC Funding	Positions
PR	- $167,800	- 1.00

2. INJURED PATIENTS AND FAMILIES COMPENSATION FUND -- OTHER PROVISIONS

Senate: No change to Joint Finance.

Assembly: Modify current law pertaining to the injured patients and families compensation fund (IPFCF) to require corporations operating in Wisconsin to participate in the IPFCF. Under current law, corporations must be both organized and operated in Wisconsin to participate in the IPFCF.

In addition, modify current law to prohibit the Governor from introducing a budget that uses funds from the IPFCF for any purpose other than a purpose specifically authorized under statutes pertaining to the IPFCF.

3. REQUIRED HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDER

Senate: Require every health insurance policy and every self-insured health plan of the state ~~or of a~~ county, city, town, village, or school district, to provide coverage of treatment for autism spectrum disorders, if the treatment is provided by any of the following: (1) a psychiatrist; (2) a psychologist; (3) a social worker who is certified or licensed to practice psychotherapy; (4) a speech language pathologist; (5) a paraprofessional working under the

supervision of a provider identified in (1) through (4); or (6) a professional working under the supervision of a certified mental health clinic. Define "autism spectrum disorder" as autism disorder, Asperger's syndrome, or pervasive developmental disorder not otherwise specified. Specify that the required coverage may be subject to any limitations, exclusions, and cost-sharing provisions that apply generally under the health insurance policy or the self-insured governmental or school district health plan. Specify that the required coverage does not apply to any of the following: (1) a disability insurance policy that covers only certain specified diseases; (2) a health care plan offered by a limited service health organization, or by a preferred provider plan, that is not a defined network plan; (3) a long-term care insurance policy; or (4) a Medicare replacement policy or Medicare supplement policy.

Specify that these statutory changes would take effect on the first day of the seventh month beginning after the bill's publication (general effective date), and that the changes would first apply to health insurance policies and self-insured governmental or school district health plans as follows: (1) except as otherwise provided, to health insurance policies that are issued or renewed, and self-insured governmental or school district health plans that are established, extended, modified, or renewed, on the general effective date; (2) to health insurance plans covering employees affected by a collective bargaining agreement containing provisions inconsistent with the coverage requirements stated herein that are issued or renewed on the earlier of the day on which the collective bargaining requirement agreement expires or the day on which the collective bargaining agreement is extended, modified, or renewed; and (3) to self-insured governmental or school district health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with the coverage requirements stated herein that are established, extended, modified, or renewed on the earlier of the day on which the collective bargaining agreement expires or the day on which the collective bargaining requirement is extended, modified, or renewed.

Assembly: No change to Joint Finance.

4. MINIMUM COVERAGE REQUIREMENTS FOR TREATMENT OF MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE PROBLEMS

Senate: Increase the minimum coverage requirements for the treatment of mental health and alcohol and other drug abuse (AODA) problems that group or blanket disability insurance policies (health insurance policies) must meet as follows.

Policies that Cover Inpatient or Outpatient Treatment, or Both. Increase from $7,000 to $20,250 the minimum dollar amount of coverage that health insurance policies that cover inpatient hospital treatment, outpatient treatment, or both must provide in each policy year for total inpatient hospital services, outpatient services, and transitional treatment services for the treatment of nervous or mental disorders and AODA problems.

Policies that Cover Inpatient Treatment. Increase from $7,000 to $20,250, minus any applicable cost sharing at the level charged under the policy, the minimum dollar amount of

coverage that health insurance policies that cover any inpatient hospital treatment must provide in every policy year for inpatient hospital services for the treatment of nervous or mental disorders and AODA problems. Increase from $6,300 to $18,250 the minimum dollar amount of coverage under these policies for inpatient services if the policies do not use cost sharing.

Policies that Cover Outpatient Treatment. Increase from $2,000 to $3,450, minus any applicable cost sharing at the level charged under the policy, the minimum dollar amount of coverage that health insurance policies that cover outpatient services must provide in every policy year for outpatient services for the treatment of nervous or mental disorders and AODA problems. Increase from $1,800 to $3,100 the minimum dollar amount of coverage under these policies for outpatient services if the policies do not use cost sharing.

Transitional Treatment. Increase from $3,000 to $5,200, minus any applicable cost sharing at the level charged under the policy, the minimum dollar amount of coverage a policy that covers either inpatient treatment or outpatient treatment must provide in every policy year for transitional treatment arrangements. Increase from $2,700 to $4,650 the minimum dollar amount of coverage for transitional services for policies that do not use cost sharing.

Require DHFS to report annually to the Governor and the Legislature on revising the coverage limits contained in the bill, based on the change in the consumer price index for medical costs.

These provisions would first apply to policies issued, renewed, or modified on the first day ~~of the 13th~~ month beginning after the bill's publication.

Assembly: No change to Joint Finance.

5. HEALTH INSURANCE -- INSURER DISCLOSURE OF CURRENT PROCEDURAL TERMINOLOGY CODE CHANGES AND EXPLANATION OF RESTRICTION OR TERMINATION OF POLICY COVERAGE

Senate: Provide that if an insurer changes the current procedural terminology code that was ~~submitted~~ by a health care provider to describe the services he or she performed, the insurer must include on the explanation of benefits form the explanation for the change and the source for the change. Define "current procedural terminology code" as a number established by the American Medical Association that a health care provider puts on a health insurance claim form that describes the services he or she performed.

Provide that if an insurer restricts or terminates coverage for the treatment of a condition or complaint and, as a result, the insured becomes liable for payment for all of his or her treatment for the condition or complaint, the insurer must provide on the explanation of benefits form a detailed explanation of the clinical rationale and the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

Provide that if, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for the treatment of a condition or complaint by a chiropractor acting with the scope of his or her license and the restriction or termination results in the patient becoming liable for payment for his or her treatment, the insurer must provide to the patient and to the treating chiropractor a written statement that includes, among other things, a detailed explanation of the clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

Under current law, insurers are required to provide to the patient and their treating chiropractor a reasonable explanation of the factual basis and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage. This amendment requires that explanation to be a detailed explanation of the clinical basis for the insurer's decision to restrict or terminate coverage. The amendment would also extend that requirement to the treatment of conditions and complaints beyond those treated by chiropractic services.

The amendment's provisions would first apply to claims for insurance coverage submitted to an insurer on the bill's general effective date. If, however, a health insurance policy or plan in effect on that date contains a provision inconsistent with these new requirements, the new requirements would first apply on the date that health insurance policy or plan is renewed.

Assembly: No change to Joint Finance.

6. HEALTH INSURANCE COVERAGE OF A FULL-TIME STUDENT ON MEDICAL LEAVE

Senate: No change to Joint Finance.

Assembly: Require every health insurance policy, including every health care plan offered by the state, and every self-insured health plan of the state or a county, city, village, town, or school district, that provides coverage for a dependent because he or she is a full-time student to continue to provide coverage for the student if he or she ceases to be a full-time student because of a medically necessary leave of absence. Specify that the student must provide physician documentation to prove that the leave is medically necessary. Further, specify that the policy must continue the coverage for the student only until any of the following occurs: (a) the student advises the policy or plan that he or she does not intend to return to school full time; (b) the student becomes employed full time; (c) the student obtains other health coverage; (d) the student gets married and is eligible for coverage through his or her spouse; (e) the student reaches an age at which he or she would no longer be covered even as a full-time student; (f) coverage of the person through whom the student has dependent coverage is discontinued or not renewed; or (g) one year has elapsed since the student's continuation coverage under these provisions began and the student has not returned to school full time.